STATE OF MICHIGAN

IN THE SUPREME COURT
(ON APPEAL FROM THE MICHIGAN COURT OF APPEALS)

BLAKEWOODS SURGERY CENTER, LLC., JACKSON MEDICAL SERVICES, INC., PAUL ERNEST, M.D., KEVIN LAVERY, M.D., ANTHONY SENSOLI, M.D., SIGMUND ANCEREWICZ, M.D., KHAWAJA IKRAM, D.O., SHARON ROONEY-GANDY, D.O., ARTHUR WIERENGA, M.D., MARTIN PATRIAS, M.D., MICHAEL CHAMES, M.D., GHULUM DASTGIR, M.D., and KABINDRA MISHRA, M.D.,

Plaintiffs-Appellants,

v.

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, in its Official Capacity

Defendant-Appellee.

_____/

Supreme Court
Docket No: 118935

Court of Appeals
No: 221494

Trial Court
No: 98-88770-CZ

BRIEF OF AMICUS CURIAE BLUE CROSS BLUE SHIELD OF MICHIGAN

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STATEMENT OF QUESTIONS PRESENTED

I. THESE APPELLANTS REFUSED TO CHALLENGE THE REMEDIAL PLAN SUBMITTED BY BLUE CROSS BLUE SHIELD OF MICHIGAN AND APPROVED BY THE COMMISSIONER OF INSURANCE WITH RESPECT TO AMBULATORY SURGICAL FACILITIES. THE REMEDIAL PROVIDER CLASS PLAN WAS THE SUBJECT OF 1980 PA 350 ADMINISTRATIVE PROCEEDINGS WHICH THESE APPELLANTS PARTICIPATED IN, LOST AND THEREAFTER DECLINED TO APPEAL. SHOULD THIS WARRANT THE AFFIRMANCE OF THE COURT OF APPEALS BECAUSE APPELLANTS HAVE MADE AN "END RUN" AROUND ADMINISTRATIVE APPELLATE JURISDICTION AFFORDED BY MCLA 550.1518 BY THE FILING OF THE WITHIN DECLARATORY JUDGMENT LITIGATION?

Plaintiffs-Appellants say "No"

Defendant-Appellee says "Yes"

Plaintiff's have not filed an appeal as required by MCLA 550.1518

Amicus Curiae Blue Cross and Blue Shield of Michigan contends the answer should be "Yes".

II. 1980 PA 350 PROVIDES APPELLANTS, THE COMMISSIONER AND BLUE CROSS WITH AN EXACTING REGULATORY, ADMINISTRATIVE PROCESS IN THE PROVIDER CLASS PLAN REVIEW SYSTEM. DOES APPELLANTS' PREFERENCE FOR DIRECT LITIGATION OF THE SAME QUESTIONS IN THE COURTS, INSTEAD OF ABIDING BY A DIRECTLY CONTROLLING ADMINISTRATIVE PROCESS, IMPLICATE THE PRIMARY JURISDICTION DOCTRINE IN A FASHION WHICH STRONGLY MILITATES AGAINST ACCEPTANCE AND REVIEW OF APPELLANTS' DECLARATORY JUDGMENT FILED IN CIRCUIT COURT?

Plaintiffs-Appellants say "No"

Defendant-Appellee says "Yes"

Amicus Curiae Blue Cross and Blue Shield of Michigan contends the answer should be "Yes".

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STATEMENT OF FACTS

The facts as set forth by Defendant-Appellee Commissioner of Financial and Insurance Services (hereinafter, "the Commissioner") will suffice for purposes of the within Brief of Amicus Curiae.

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STATEMENT OF INTEREST

Blue Cross Blue Shield of Michigan is the health care corporation chartered by the Michigan Legislature pursuant to 1980 PA 350, the Non-Profit Health Care Corporation Reform Act, MCLA 550.1101, et. seq.

Under the regulatory system created by the Michigan Legislature under 1980 PA 350, Blue Cross Blue Shield of Michigan (hereinafter, "Blue Cross") has placed upon it three (3) global, consolidated and balanced operational goals of (1) quality of health care, (2) access of all subscribers to health care, and (3) the ultimate containment of spiraling health care costs essential to the continued maintenance of private medical practice health care. See MCLA 550.1504(1). Blue Cross operates under a comprehensive statutory scheme that requires that all three (3) of these statutory goals must be deemed met by the Commissioner, balanced as they must be, for Blue Cross to satisfy the 1980 PA 350 legislative mandate of providing high quality, reasonable cost health care to an appropriate number of subscribers throughout the state. To accomplish the delicate contract qualification standards, reimbursement arrangements and requirements, the balance of these crucial goals, in turn, health care reimbursement mechanisms used by Blue Cross must meet the MCLA 550.1504 directives for these statutory goals, goals which remain the prime directive for Blue Cross when contemplating entering into participating provider agreements with various

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health care providers to extend those services to Michigan subscribers. For the benefit of its subscribers, who comprise a very substantial portion of the population of Michigan, Blue Cross may enter into contractual reimbursement arrangements for approved providers, based upon its goal of reasonable access to health care, taking into account an appropriate number of providers and the overall complementary strengths of the health care system in Michigan, taken as a whole. This must be done so that those approved providers will meet reasonable standards of health care quality as well as ensuring that benefits paid out to such participating providers will always meet the cost goals.

As part of this bedrock Legislative Mandate of balanced statutory goals, Blue Cross would and could elect to enter into participating provider agreements with freestanding ambulatory surgical facilities. But this decision for each such provider would be based upon standards set forth by Blue Cross Blue Shield of Michigan pursuant to its powers to promulgate such standards under MCLA 550.1502(8). As a matter of longstanding legal history, Blue Cross has, generally speaking, been upheld in terms of its selection of participating providers, in part, on grounds that Blue Cross' approval did not preclude providers from treating patients; the only effect, legally speaking, of Blue Cross' declination to enter into a participation contract with a provider was that subscribers could not obtain reimbursement from Blue Cross Blue Shield of Michigan as to such nonparticipating

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providers. See, for example, Psychological Services of Bloomfield Inc., v Blue Cross Blue Shield of Michigan, 144 Mich App 183, 375 NW2d 382 (1985).[1]

Recently, however, several cases have surfaced in the Courts, seeking to wrest from Blue Cross' control its fundamental decisionmaking power in connection with the approval of participating providers as ambulatory surgical facilities[2], in particular.

The most direct challenge to the power of Blue Cross to approve ASF Providers before the instant Blakewoods litigation was Greater Lansing Ambulatory Surgery Center Company, LLC, v Blue Cross and Blue Shield of Michigan, 1999 WL 3347021, app. den. 461 Mich 966, 609 NW2d 186, reh. den., 461 Mich 966, 626 NW2d 411 (2000). There, the Court of Appeals upheld (and our Supreme Court let stand) the Blue Cross ambulatory surgical provider facilities' standards encompassed by MCLA 550.1502(8). This unpublished decision was based on the opinion in

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[1] Blue Cross offers benefits to its members for ambulatory surgical facility services under the ASF coverage rider, approved by the Insurance Bureau. The Bureau-approved rider limits facility benefit to Blue Cross "participating" facilities as part of the health care benefit design. Non-participating facilities (e.g., where Blue Cross has chosen not to contract), are not a paid facility service benefit. The physician's charges on the other hand are paid under the member's general medical-surgical benefits.

[2] See Genesis Center, P.L.C. v Financial and Insurance Services Commissioner, 246 Mich App 531, 633 NW2d 834 (2001); Blakewoods Surgery Center, LLC, et. al., v Michigan Insurance Commissioner, 2001 WL 776565; Vision Institute of Michigan v Blue Cross Blue Shield of Michigan, 2001 WL 815411. See, also, PT Today, Inc., v Blue Cross and Blue Shield of Michigan, 2001 WL 824462. Blakewoods Surgery Center, et. al. v. Blue Cross Blue Shield of Michigan, lev. den. 463 Mich 976, 623 NW2d 595 (2001).

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Psychological Services of Bloomfield Inc., v Blue Cross and Blue Shield of Michigan, 144 Mich App 182, 375 NW2d 382 (1985).

While Blue Cross has previously repeatedly, successfully defended its Evidence Of Need (EON)[3] standards under MCLA 550.1502(8), a modification to the system was deemed necessary by the Commissioner in his review of the Provider Class Plan the Order and Determination Report dated March 30, 2000.[4] There, the Commissioner determined that Blue Cross did not achieve two (2) of the three (3) statutory goals (qualified access goals) for the Ambulatory Surgical Facility (hereinafter, "ASF") Provider Class Plan for the two-year period under review. The Commissioner found that since Blue Cross failed to meet the access and quality goals, it was required under Section 510(2) to submit a "remedial" provider class plan that "substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the Commissioner"

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[3] The Evidence of Necessity/Need (EON) standard found in Blue Cross' currently effective Ambulatory Surgery Facilities (ASF) provider class plan is a reasonable standard permitted by the various sections of MCLA 550.1101 et. seq., the statute which regulates Blue Cross Blue Shield of Michigan. By including Evidence of Necessity as a requirement in its provider class plan, Blue Cross addresses the needs of its members in a given geographic area. This is not only permissible, but contemplated under the Act. MCLA 550.1502(8); 530.1504; 550.1516. The practice has also been sanctioned by the Courts. Psychological Services of Bloomfield, 144 Mich. App. 182; 375 N.W.2d 382 (1985); Blakewoods et al. v. Blue Cross Blue Shield of Michigan, lv. den. 463 Mich 976, 623 NW2d 595 (2001).

[4] The Act provides that the Commissioner, when reviewing a provider class plan, shall- as he did here- consider comments made by individual providers or from organizations and associations that represent the provider class in question. MCLA 550.1505(2) & 550.1509(4)(e). The statutorily articulated goals only apply to Blue Cross' relationship with its subscribers. MCLA 550.1504(1); Blue Cross and Blue Shield of Michigan v. Milliken, fn. 38 at 422 Mich. 1, 50; 367 N.W.2d 1, 26 (1985).

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under Section 510(2). MCLA 550.1510(2) and 550.1511(1). Blue Cross was ordered to submit a new ASF Provider Class Plan within six (6) months of the Commissioner's Determination Report. (Attachment "A", page ii). The Commissioner, furthermore, determined, by that Order and Determination Report dated March 30, 2000, that Blue Cross' EON standards were not reasonable and were not being uniformly applied. The Commissioner's Plan review, commenced in July of 1999, was completed and the Determination report was thereafter issued. (Attachment "A"). The Commissioner's Report specifically addressed the EON criteria used by Blue Cross. While the Report did, indeed, criticize Blue Cross' unlimited application of discretion in the EON standards in that particular ASF Provider Class Plan as originally formulated by Blue Cross, it also simultaneously, wholly rejected Plaintiffs-Appellants' arguments for automatic rights to participation agreements exclusively based on State of Michigan Certificate of Need (CON) determinations. The Report embraced the concept of EON criteria in theory, and upheld Blue Cross' use of EON standards, circumscribed by a surgical volume requirement, so that ASF operating rooms had some relationship to need and surgical flow:

> "**BCBSM should establish reasonable EON guidelines that will be applied uniformly throughout the state**...However, new EON guidelines need not act to allow any and all ASFs to participate. **BCBSM is justified in keeping a needs based [EON] formula, however, this formula should be applied reasonably and uniformly for all providers**... In computing EON, there should be a minimum number of

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> procedures performed per room (e.g. 1200)…**In order to be eligible to participate with BCBSM, an ASF should be able to demonstrate that it is currently performing at least 900 cases a room per year for non-BCBSM subscribers…**" (See Attachment "A"; March 30, 2000 Determination Report, page 21). [Emphasis Supplied].

Under the current statutory scheme, the Commissioner is vested with the regulatory authority to solicit input and conduct public hearings, which the Commissioner did before issuing his Determination Report. See MCLA 550.1505(2); 550.1509(4). The Commissioner is required to consider the "overall balance" of the statutory goals as well as information gathered that pertains to health and economic trends, changes in legislation, and comments and arguments from interested persons who may choose to comment. MCL 550.1505(2); 550.1509(4). Appellants fully participated in the public hearings and submitted input to the Commissioner as provided in the statute, making the same arguments challenging Blue Cross' Evidence of Necessity requirement as they have made in this case. Plaintiffs-Appellants indisputably took advantage of that administrative process to fully participate in these extensive public hearings conducted by the Commissioner; Appellants, indeed, submitted oral argument as provided by statute. (Attachment "B"[5], pp 3-4).

On May 1, 2000, Appellants filed a challenge to the Commissioner's March 30, 2000 determination, requesting a

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[5] February 23, 2000 Hearing Report, page 3, Linda Fausey the ninth speaker representing Blakewoods and SCM Surgery Center.

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contested case hearing under the Administrative Procedures Act before an Independent Hearing Officer ("IHO"), all of which is plainly established by the 1980 PA 350 statute [MCLA 550.1515(1); MSA 24.660(515)]. That case, instituted by Appellants, was entitled, Blakewoods Surgery Center et al. and, Vision Institute et al. v. Frank M. Fitzgerald, Insurance Bureau Docket No. 20001023. Under the statute, the IHO conducts the proceedings as a full-blown contested case, keeping under the MCLA 24.301 Administrative Procedures Act [MCL 550.1515(2)]. See, In Re 1987-88 Medical Doctor Provider Class Plan, 203 Mich. App. 707; 514 N.W.2d 471 (1994).

Pursuant to MCLA 550.1514; MSA 24.660(514), a hearing was held in the contested case on October 30, 2000, before the Independent Hearing Officer (hereinafter, "IHO"), James K. Nichols, who dismissed Appellants' appeal as to the substance of identical legal challenges presented here. The IHO's Order Affirming the Commissioner's March 30, 2000, determination and an order dismissing the contested case hearing was issued November 29, 2000. (Attachment "C"). In his Order, the IHO held that:

> **"6. On May 1, 2000 Petitioners filed their "Joint Petition for Review"...The Petitioners also alleged that the Plan was *ultra vires* because it provided that Ambulatory Surgical Facilities had to meet an Evidence of Need standard established by BCBSM. Finally, Petitioners alleged that BCBSM failed to recognize the Petitioner's license...**
>
> *** * ***
>
> **12. The issues raised by Petitioners in their Joint Petition for Review are legal issues which are exclusively**

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within the authority of the IHO. Therefore, no testimony need be taken to resolve those legal questions…

* * *

15. The Commissioner properly concluded that BCBSM could have reasonable Evidence of Need standards applicable to all licensed Ambulatory Surgical Facilities who wish to participate with it…

* * *

16. The Commissioner correctly decided that BCBSM need not reimburse every licensed Ambulatory Facility. BCBSM is not required to participate with every licensee….

18. Thus, the issues raised by Petitioners…are legal issues which the Commissioner properly resolved in his Decision of March 30, 2000." "*Findings and Order Affirming The Commissioner's Order Issuing Determination Report Dated March 30, 2000*", *Blakewoods Surgery Center et al. v. Frank M. Fitzgerald*, Insurance Bureau Docket No. 20001023. [See Attachment "C"] [Emphasis Supplied]

Appellants elected not to file an appeal to the Michigan Court of Appeals which Appellants had a clear right to do under MCLA 550.1518. Thus, precisely the parallel issues Appellants have raised here before our Supreme Court were previously raised in the context of the review and appeal of the ASF Provider Class Plan, arguments which were rejected by the Commissioner and affirmed by the IHO, without Appellants having filed a proper and conclusive leal challenge by the established procedure set down by MCLA 550.1518.

The relevant statute provided Appellants with an opportunity to appeal the IHO's November 29, 2000 "Findings and Order Affirming The Commissioner's Order Issuing Determination Report

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Dated March 30, 2000". MCLA 550.1518; MSA 24.660(518). (Attachment "C"). Under the cited statute, the IHO Order could have been appealed under the Michigan Administrative Procedures Act to the Court of Appeals within thirty (30) days. MCLA 550.1518; MSA 24.660(518). Appellants failed to appeal that Order and chose not to proceed. The time for their appeal has now expired. MCLA 550.1518; MSA 24.660 (518).

As a result of the Commissioner's March 30, 2000 Determination, Blue Cross Blue Shield of Michigan was required to (and did) submit a remedial plan to the Commissioner on December 29, 2000 as required by the portion of the statute relating to remedial provider class plans. MCLA 550.1511(1). (Attachment "D"). Following its solicitation and consideration of input from providers and other interested persons, Blue Cross drafted and submitted this remedial class plan to the Commissioner.[6] On March 29, 2001, the Commissioner determined the "remedial" plan as modified by Blue Cross substantially achieved the goals, achieved the objectives, and substantially overcame the deficiencies previously enumerated by the Commissioner; as such, the Commissioner retained the modified Remedial Plan rewritten by Blue Cross. MCLA 550.1513(1). (Attachment "D"). The Blakewood Appellants **did not** file an appeal of that Order of the

[6] In accordance with the statute, before drafting and submitting the remedial plan, Blue Cross solicited and considered input form interested persons, including ASF providers. Indeed, Appellant Blakewoods itself participated in providing input to Blue Cross in Blue Cross' formulation of the remedial class plan. MCLA 550.1511(1). (see Attachment "B").

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Commissioner, although they could have done so under MCLA 550.1515 by the filing of a new Petition For review, requesting a new IHO and a new Contested Case Hearing. This, again, Appellants did not do, apparently preferring their original Circuit Court action over the established administrative procedures called for by MCLA 550.1518 and/or MCLA 550.1515. In short, on two crucial occasions, Appellants abandoned their appellate rights knowingly.

Blakewoods is currently a participating ambulatory surgical facility, having met Blue Cross' qualification standards as of October 9, 2001 and having entered into a participation contract with Blue Cross Blue Shield of Michigan at that time. Their major contentions on the score of not being a participating provider ceased to exist as of that date.

In January 2002, the Commissioner approved under MCLA 550.1508, modifications of Blue Cross' remedial plan, which retained the EON qualification standards, as modified. (See Attachment "F", Order Approving Modifications and Attachment "G", the Modified Remedial Class Plan). Appellants **did not** appeal that decision, although they certainly could have done so under MCLA 600.631. Instead, Appellants chose a wholly different litigation strategy, one designed to relitigate the matter in the Courts, notwithstanding clearcut, contradictory appellate rights under MCLA 550.1518. This was done by Appellant, Blakewoods, by maintaining the suit filed by the Declaratory Judgment litigation against the Commissioner who has been ably defended by the Office

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of Attorney General from the onset of this suit to the present time.

Because 1980 PA 350 implications here are crucial, because Appellants have disingenuously avoided the active participation that these Appellants themselves have previously engaged in with respect to the provider class plan appeal (see Attachment "B") and in the administrative process which allowed them to enjoy substantial appellate jurisdiction to challenge the standards approved by the Commissioner, because Appellants were free to challenge the modified Plan as a matter of law under MCLA 550.1518, because Appellants' litigation in this Court inherently abjures traditional concepts of the Primary Jurisdiction Doctrine which acknowledge the expertise of the regulators, as well as encompassing traditional Administrative Procedure Act (MCLA 24.301, et. seq.) appellate rights to challenge those decisions, this Amicus Curiae Brief becomes necessary to explain that which Appellant has diligently avoided explaining. As a result of this analysis, Blue Cross Blue Shield of Michigan respectfully submits that it is sufficiently vested with interest to appear before this Court as Amicus Curiae to speak to these two (2) issues, however briefly. These issues are elaborated upon as follows.

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ARGUMENT

I.

THESE APPELLANTS REFUSED TO CHALLENGE THE REMEDIAL PLAN SUBMITTED BY BLUE CROSS BLUE SHIELD OF MICHIGAN AND APPROVED BY THE COMMISSIONER OF INSURANCE WITH RESPECT TO AMBULATORY SURGICAL FACILITIES. THE REMEDIAL PROVIDER CLASS PLAN WAS THE SUBJECT OF 1980 PA 350 ADMINISTRATIVE PROCEEDINGS WHICH THESE APPELLANTS PARTICIPATED IN, LOST AND THEREAFTER DECLINED TO APPEAL. THIS WARRANTS THE AFFIRMANCE OF THE COURT OF APPEALS BECAUSE APPELLANTS HAVE MADE AN "END RUN" AROUND ADMINISTRATIVE APPELLATE JURISDICTION AFFORDED BY MCLA 550.1518 BY THE FILING OF THE WITHIN DECLARATORY JUDGMENT LITIGATION.

Appellants have engaged in a central litigation dissimulation before the Supreme Court by refusing to acknowledge that they failed to complete an administrative process and an administrative appeal which they themselves started and, ultimately, abandoned. Such participation in the administrative process is mandated under MCLA 550.1514, MCLA 550.1515, MCLA 550.1516 and MCLA 550.1518; Appellants began the process, participated in it, but jettisoned the established statutory procedures once the decisional flow started to go against them. The fundamental question is, should Appellants be able to get away with the indefensible avoidance of the exclusive administrative process?

When the Commissioner concluded that the Blue Cross' modified plan would consider approval of ambulatory surgical facilities (ASF) as a participating provider based upon a minimum

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Twelve Hundred (1,200) surgeries per year per operating room (for participating ASFs, or Nine Hundred (900) for non-participating), the approved EON standard as modified, the Commissioner determined that such criteria was favorable and apparently properly reserved by Blue Cross under MCLA 550.1502(8). The autonomic, "knee-jerk" approval sought by the ASF Providers[7] was wholly dismissed "out-of-hand" by the Commissioner. The necessary qualifications standard asserted by Blue Cross which was ultimately approved by the Commissioner demonstrated a true need for the facility by establishing a meaningful volume requirement for the number of surgeries conducted in each operating room. Blue Cross utilizes participation criteria as part of a general scheme to comply with its statutorily mandated goals with respect to its subscribers of reasonable access, cost and quality of covered health care services.[8] Blue Cross may set reasonable standards for participation as necessary to comply

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[7] The ASF Providers argued for this alternative criterium: if the State had granted a Certificate Of Need for the mere **building** of the facility, the provider should automatically be approved by Blue Cross as a participating provider, with nothing else required. This is highly similar to the present Supreme Court appeal.

[8] By including Evidence of Necessity as a requirement in its provider class plan, Blue Cross addresses the needs of its members in a given geographic area. This is not only permissible, but contemplated under the Act. MCLA 550.1502(8); 530.1504; 550.1516. The practice has also been sanctioned by the Courts. Psychological Services of Bloomfield, 144 Mich App 182; 375 NW2d 382 (1985). Blakewoods et. al. v. Blue Cross Blue Shield of Michigan, lv. den. 463 Mich 976, 623 NW2d 595 (2001) ("...[A] determination of need by the state serves a different purpose than a determination of need by defendant [Blue Cross]...Defendant's [Blue Cross'] determination of need focuses only on the needs of defendant's [Blue Cross'] subscribers, as opposed to the needs of the public as a whole, and defendant [Blue Cross] has authority to establish standards to limit the number of participating providers where necessary to keep costs down and quality high..."). Slip Op. at 4.

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with Part 5 of the Act. MCLA 550.1502(8); MCLA 550.1504(1); MCLA 550.1207(1)(w).

Blue Cross' EON is a planning methodology that determines the amount of provider services Blue Cross needs in a specific geographical area and allows Blue Cross to participate with the minimum number of providers required to adequately deliver services to Blue Cross members in a benefit program. If Blue Cross determines that there are sufficient providers in a service area, Blue Cross does not approve new facilities for participation until existing providers withdraw as a Blue Cross provider or the number of services required in an area increases. Blue Cross attempts to achieve appropriate access to covered health care services for Blue Cross members, while also ensuring the service is provided at a reasonable cost. Blue Cross therefore does not contract with an ASF unless its members are in need of the additional capacity.

Meeting that minimum number was set as the sine qua non determinant as to whether the ambulatory surgical facility could be a "participating provider". Without the requisite Twelve Hundred (1,200) surgeries per year per operating room (or 900 for non-participating)being shown to establish need and necessary surgical flow, Blue Cross Blue Shield of Michigan could, indeed, reject the facility's application to participate, the proposed facility, pursuant to MCLA 550.1502(8), the Commissioner ruled. Given the statutorily recognized authority of rejection under the

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Blue Cross standards of Evidence Of Need articulated under MCLA 550.1502(8), as opposed to the autonomic, "knee-jerk" Certificate of Need position of Appellants, Blue Cross' position was upheld, with modifications.

The Commissioner's approval of Blue Cross' modified plan requiring a minimum number of surgeries was held to be the "bedrock" basis for the approval of ASF's as "Participating Providers". Thus it was a ruling which provided a decision wholly appealable to the Court of Appeals under MCLA 550.1518. As the new plan was formulated and wended its way through the statutory process, commencing with MCLA 550.1511, ultimately, Appellants decided to participate, appealing of the Determination of the Commissioner, as was their right under MCLA 550.1514, MCLA 550.1515, MCLA 550.1516 and MCLA 550.1518, while at the same time, providing input to Blue Cross in formulation of the new remedial plan. MCLA 550.1511(1); 550.1505. (see Attachment "B"). Because Appellants decided **not** to appeal the Independent Hearing Officer's Order of November 29, 2000, affirming the Commissioner's Order of March 30, 2000, and the Commissioner's Order of March 29, 2001, approving Blue Cross' newly rewritten ASF Provider Class Plan, an extremely important litigation event took place by virtue of that decision. (Attachments "A", "C" and "E"). Appellants' counsel simply jettisoned the important administrative process at the crucial point of a potential, recognized appeal, and thus, the time to appeal available under

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MCLA 550.1518 expired. Instead, Appellant decided to maintain a previously filed, parallel Declaratory Judgment Act litigation under MCR 2.605(A). This was a tactic completely outside of established appellate administrative procedure mandated by the Administrative Procedures Act statute. MCLA 24.301 et. seq.

Under both concepts of res judicata and collateral estoppel, we contend, Appellants have, in effect, fatally imperiled their right to maintain this Declaratory Judgment Act litigation by refusing to "follow through" with the appeal of the administrative decisions below called for under MCLA 550.1518. Again, this litigation choice **not** to appeal was fatal, we contend. Consider the following analysis.

The extremely intricate and exhaustive process of dealing administratively with a provider class plan is more fully detailed in the seminal case of In Re: 1987-1988 Medical Doctor Provider Class Plan, 203 Mich App 707, 514 NW2d 471 (1994). In that case, the Court of Appeals did an excellent review of the stunning array of procedural safeguards and litigation procedural vicissitudes which painstakingly inhere in the excruciatingly detailed provider class plan review undertaken pursuant to MCLA 550.1501, et. seq. In recognition of administrative expertise of health care regulators and the legislative delegation of regulation to the Commissioner, the Court of Appeals denounced a rather bizarre decision by former Circuit Judge Robert Borsos which fundamentally threatened privatized health care in

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Michigan. An appellate rescue was accomplished by the Court of Appeals by reversing the decision by Judge Borsos outright and by reaffirming the approval of the provider class plan by the then-sitting Insurance Commissioner. What is truly important about that reported case, however, for our purposes, is, first of all, the very rich study of how exhaustively detailed the provider class plan procedure is and how painstaking the administrative hearing appeal process is as well and, secondly, how well an appeal of an unsatisfactory administrative decision could adjust an incorrect administrative decision under MCLA 550.1518.

Though here Appellants originally chose to file their grievance in the Ingham County Circuit Court as a Declaratory Judgment action, Appellants received several adverse administrative decisions which they now virulently attack in the Michigan Supreme Court. We submit that Appellants' suit was precluded by the res judicata doctrine as there was no appeal of the administrative proceedings which Appellants voluntarily engaged in, lost and failed to appeal under MCLA 500.1518 and/or MCLA 550.1515. This original choice is wholly inapposite to the current statutory scheme set forth and which is more fully detailed throughout this brief. MCLA 550.1502; 550.1511; 550.1514; 550.1515; 550.1516; 550.1518.

Consider the analogous authority of Curry v City of Detroit, 394 Mich 327, 231 NW2d 57 (1975). There, the trial court accepted the City's claim of governmental immunity as a complete

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defense. This dismissal was then appealed on Application to the Michigan Court of Appeals which denied the interlocutory application for leave to appeal. Because no appeal was thereafter taken by Curry to the Michigan Supreme Court, the original decision became final and binding. A second suit was thereafter filed between the same parties, relating precisely as to the same subject matter and which was centered around the same legal point, exactly as Appellants have done here. Under Curry, this avoidance-of-first-decision tactic became fatally tainted under the res judicata doctrine. Consider what the Curry Supreme Court said on this point:

> The second suit was between the same parties in the same position as plaintiff and defendant. The subject matter involved was the same. The legal point involved was the same. If the double filing is allowed in this case, it follows that any possible 'final' adverse ruling can be likewise circumvented. Several questions then call for answers. For instance, how long after the first adverse decision may one wait before filing another complaint and how many such complaints can be filed?
>
> Jones v Chambers, 353 Mich 674, 91 NW2d 889 (1958) said where issues of law 'have been finally decided by a court of competent jurisdiction in 1 legal action which are essential to the maintenance of another legal action, it is universally held that the second action must fail'. Accordingly, this second action must fail.

As was also stated in Ferguson v Village of Montrose, 75 Mich App 596, 597, 255 NW2d 700 (1977), the rule of Curry applies here, and that rule is very simple: that any Order constituting a

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Final Judgment capable of being appealed which is not then timely appealed and which tends to relate to exactly the same issues as are raised by a second lawsuit justifies the refusal of the Courts to hear the second case under the res judicata doctrine.

Michigan follows the broad application of res judicata issue preclusion principles to bar not merely claims identical to those already litigated in a previous suit but which also shall extend conclusively as to those claims arising out of the same transaction which the Appellant could have brought but which he or she did not bring. See Gose v Monroe Auto Equipment Company, 409 Mich 147, 294 NW2d 165 (1980); Brookins v General Motors Corp., 843 F2d 879 (6th Cir. 1987)(once a matter has been fully and without reservations submitted to a tribunal, an adverse decision must be appealed; if it is not appealed, principles of res judicata operate to preclude similar issues in all other later forums).

Consider, once again, the detailed analysis of the adjudicatory process available for administrative review of provider class plans afforded by MCLA 550.1515 and/or MCLA 550.1518. See In Re: Provider Class Plans, supra. Blue Cross and the Commissioner are entitled to preclude alternative litigation in Court as to the issues previously decided and arising under the provider class plan because an earlier administrative determination was directly adjudicatory in nature, with a full-blown APA hearing, no less, was not appealed under

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MCLA 550.1518, nor was a subsequently approved remedial plan convened under MCLA 550.1511 ever challenged as was Appellants' rights to do so under MCLA 550.1515. There was clearly provided, in addition, a right to appeal the administrative decision, and the Legislature obviously intended the decision of the Commissioner to be final and binding, absent appeal prosecuted under MCLA 550.1518. See Nummer v Treasury Department, 448 Mich 534,542, 533 NW2d 250 (1995), citing Senior Accountants, Analysts & Appraisers Association v Detroit, 399 Mich 449, 457-458, 249 NW2d 121 (1976); Roman Cleanser Company v Murphy, 386 Mich 698, 703-704, 194 NW2d 704 (1972) and Storey v Meijer, Inc., 431 Mich 368, 373, 429 NW2d 169 (1979).

The Curry rationale, if applied to the administrative process, appears to be dispositive. While the Commissioner has noted that res judicata issue to be a dispositive ground in passing, the scope of this crucial issue has not been truly considered in depth. Blue Cross Blue Shield of Michigan respectfully requests that this Court consider dismissing the Grant of Leave in Appellants' favor, as having been improvidently granted. To repeat, Appellants themselves were "aggrieved" by the March 30, 2000, Provider Class Plan Determination Report (Attachment "A"), the November 29, 2000 Order of the Independent Hearing Officer (Attachment "C"), and, most importantly, the March 29, 2001, Order Approving the Modified Provider Class Plan as rewritten by Blue Cross as a Remedial Plan (See Attachment

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"E"). Is it clear to our Supreme Court that Appellants **actively** participated in the administrative proceedings before the Commissioner, the IHO and in provider input to remedial plan formulation, Attachment "B" makes it quite clear. There was no appeal to the Court of Appeals on the IHO ruling as expressly authorized by MCLA 550.1518. Additionally, there was no MCLA 550.1515 Petition for Review as to March 29, 2001 Order, although expressly called for by 1980 PA 350.

Put bluntly, the precise issues dealt with here by Appellants were never timely appealed to the Court of Appeals or, later, to the IHO on the remedial plan. We say the Supreme Court should not have granted leave in such a case, as it is riddled with overwhelming procedural problems, all voluntarily brought about by Appellants' own litigation strategies.

Under the circumstances, Blue Cross Blue Shield of Michigan respectfully requests that the Supreme Court review the lack of gravity in Appellants' appeal when it is compared to the inexcusable avoidance of the MCLA 550.1518 and MCLA 550.1515 administrative appellate process. Indeed, as to the original administrative process before the Independent Hearing Officer under MCLA 550.1515(2), no appeal as taken to the Michigan Court of Appeals under MCLA 550.1518, and, just as significantly, there was no Petition For Review Of The Remedial Plan under MCLA 550.1515 filed. These procedural safeguards make 1980 PA 350 a superior litigation vehicle for this numbingly intricate legal

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work, as all proceedings are all conducted pursuant to the "contested case hearings" standards of the Administrative Procedures Act, MCLA 24.301, et. seq. Appellants' preferences for a front-line judicial remedy by way of Declaratory Judgment is of no consequence. Does the Supreme Court really wish to grant to disgruntled administrative appellate litigants an "end run" litigation alternative, to get around a minutely detailed creation of the Legislature for resolution of remarkably difficult regulatory matters, by going directly to Court, when a rock-solid administrative system was designed to protect the providers, the public and Blue Cross?

Under the circumstances, Blue Cross Blue Shield of Michigan states with confidence that Appellants' parallel attacks on the Provider Class Plan reflected by the instant Appeal to the Michigan Supreme Court should all be rejected on appellate jurisdiction grounds. The Application For Leave To Appeal should be dismissed as having been improvidently granted.

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II.

1980 PA 350 PROVIDES APPELLANTS, THE COMMISSIONER AND BLUE CROSS WITH AN EXACTING REGULATORY, ADMINISTRATIVE PROCESS IN THE PROVIDER CLASS PLAN REVIEW SYSTEM. APPELLANTS' PREFERENCE FOR DIRECT LITIGATION OF THE SAME QUESTIONS IN THE COURTS, INSTEAD OF ABIDING BY A DIRECTLY CONTROLLING ADMINISTRATIVE PROCESS, IMPLICATES THE PRIMARY JURISDICTION DOCTRINE IN A FASHION WHICH STRONGLY MILITATES AGAINST ACCEPTANCE AND REVIEW OF APPELLANTS' DECLARATORY JUDGMENT FILED IN CIRCUIT COURT.

As can be seen from Argument I, there is an extremely complex and beneficial administrative process under 1980 PA 350 in dealing with, precisely stated, the identical administrative issues which are now before the Michigan Supreme Court.[9] The remarkably detailed administrative process, which begins with the Commissioner, finally devolves to an appeal before an Independent Hearing Officer, with full Administrative Procedures Act, "contested case" hearings, and then back to the Commissioner and the Health Care Corporation for a possible remedial plan, a system which provides the parties with an panoply of safeguards. This litigation matrix provides subscribers, providers, the Commissioner of Financial And Insurance Services and Blue Cross Blue Shield of Michigan with a plenary opportunity for everyone to resolve all disputes, legal and factual, before and by that administrative process. Again, the extraordinarily complex

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[9] **Twice** Appellants had available appellate rights they chose not to follow through upon, although MCLA 550.1518 and MCLA 550.1515 guaranteed those appeals, as our Attachments clearly demonstrate.

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provider class plan administrative trial and appellate review system is more fully described in the case of In Re: 1987-1988 Medical Doctor Provider Class Plan, 203 Mich App 707, 514 NW2d 471 (1994).

For their own strategic reasons, however, Appellants appeared to have abandoned a viable appeal to the Michigan Court of Appeals plainly allowed pursuant to MCLA 550.1518 and then, a second right of appellate review was abandoned as to the remedial plan, a review automatically called for under MCLA 550.1515. When the provider class plan review and Determination Report issued in March of 2000 by the Commissioner, did not reach a conclusion with a result that Appellants believed wholly favorable (See Attachment "A"), the complex administrative trial/appellate process left fully available a formal judicial appeal to the Court of Appeals. Once the IHO ruled against Appellants (See Attachment "C"), Appellants simply jettisoned the important administrative process at the crucial point of a judicial appeal called for by MCLA 550.1518. Secondly, once the remedial plan drafted by Blue Cross was finally approved by the Commissioner (See Attachment "E"), no MCLA 550.1515 Petition For Review was filed, although Appellants clearly had that option available, despite clear administrative appellate rights to that effect. The waiver of these appellate rights are inexplicable, until one sees that Appellants cast their rights off in the vein of additional "forum shopping", as Appellants had done none too

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well before the Commissioner and the IHO. Simply stated, Appellants elected to try their luck before the Courts, as they certainly had not done well exhausting traditional statutory appellate and petition avenues secured under 1980 PA 350.

Therefore, Appellants have, in legal effect, litigated this case in the Courts as if they were freed from the "Laws of Gravity" and as if they have been wholly unencumbered by the administrative processes in which they "lost". The administrative results achieved by Appellants, thus far, are obviously not to their liking, having failed to appeal the Orders of the Independent Hearing Officer and the Commissioner, which remained subject to all recognized administrative appellate challenges existent under MCLA 550.1518 and 550.1515, respectively. Because the time for appeal has now long expired, should Appellants be allowed to explore Judicial Relief, unencumbered by the exclusive statutory administrative procedures set forth by 1980 PA 350, the Act by which Appellants enjoy any of their legal rights, if they exist at all?

When a review of the voluminous briefs filed by Appellants and the excellent briefs also filed by the Commissioner is made, a quiet point jumps out at Blue Cross Blue Shield of Michigan, a point which has not been fully developed and which may not occur to the Supreme Court unless it is sharply emphasized and colorfully pinpointed: that is, the Primary Jurisdiction Doctrine has received an ameliorative Renaissance in Michigan and this may

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be one more instance of its salutary application. This is a legal trend Appellants would certainly prefer the Supreme Court simply forget. We reinforce the Court's recall by this Amicus Curiae Brief.

A PRIMARY JURISDICTION PRIMER

For those areas of industry affected with the public interest, those quarters of commerce which are subject to highly complex regulation by the government, such as in utilities, health care and the telecommunications industries, there has always been a very strong preference for the Courts to accede to the superior administrative expertise of the regulating agencies, subordinating traditional, damage-style civil litigation pending before the Courts to be suspended in favor of substantial deference to and preliminary decisionmaking by the administrative agencies whose parallel jurisdiction includes the scope of exacting regulation. In Rinaldo's Construction Corp. v Michigan Bell Telephone Company, 454 Mich 65, 559 NW2d 647 (1997), citing with approval United States v Western Pacific Railway Company, 352 US 59, 77 S.Ct 161, 1 L.ED.2d 126 (1956), the Supreme Court observed:

> Primary jurisdiction...applies where a claim is originally cognizable in the courts and comes into play whenever enforcement of the claim requires resolution of issues which, under a regulatory scheme, have been placed within the special competence of an administrative body.

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According to Rinaldo's, 454 Mich at 70, the Primary Jurisdiction Doctrine is, therefore, a concept of judicial deference and discretion focused juridically on allowing the administrative agencies charged with legislative jurisdiction to proceed to make important decisions in matters of their legislatively endowed competency. This is done in recognition of the superior administrative acumen of those carefully selected legislative administrative deputies. These specialized agencies, such as the Office of Financial and Insurance Services, have obviously been vested by the Michigan Legislature with the specific authority to serve as industry "watchdog", to establish various rules, regulations and codes in the complicated (and often inscrutable) area of utilities, health care and telecommunications regulation, for the protection of the public.

As Rinaldo's holds, the Courts must acknowledge the superior administrative experience of the regulatory agency and bow to the resolution of complex issues by that specialized body. Under a regulatory scheme, complex matters in a special area have been placed with the special competency of an administrative body, charged as it is with unusually detailed regulatory experience. Rinaldo's, supra, at 71. To test whether the Primary Jurisdiction Doctrine ought to be applied, Rinaldo's, supra, at 71-72 found three (3) decisional criteria for the Bench and Bar to follow, to be held as of importance in determining whether the

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Courts should defer to the administrative agency. These are as follows:

- a Court should consider "the extent to which the agency's specialized expertise makes it a preferable forum for resolving the issue..."
- the Court should consider the need of the public and the administrative agency for uniform resolution of the litigated issue, and
- the Court should make consideration of "...the potential that judicial resolution of the issue will have an adverse impact on the agency's performance of its regulatory responsibilities....".

But here, the Primary Jurisdiction Doctrine is an even greater compelling force when the Commissioner has decided the matter (see Attachments "A" and "E"), the administrative appeal covered under MCLA 550.1515 has already resulted in dismissal as to Appellants' claim (Attachment "C"), there is **no** MCLA 550.1518 appeal to the Court of Appeals and the resultant approved Remedial Plan ordered in face (Attachment "E") is not even challenged by the administrative appellate process called for by MCLA 550.1515. And because Appellants have **already** participated and lost in that process (Attachment "B"), the Primary Jurisdiction Doctrine takes on even greater ramifications.

While paying lip service to a few current Primary Jurisdiction cases of this Court, Appellants virtually ignore the Primary Jurisdiction Doctrine in its pragmatic effect, as well as the criteria set forth in Rinaldo's, supra, at 71-72. Obviously, the regulatory agency with virtually monolithically superior expertise, here, is the Office of Financial and Insurance Services (Insurance Bureau) under 1980 PA 350. In consideration

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of whether the Primary Jurisdiction Doctrine militates against post-hoc Provider Class Plan judicial review (especially when the MCLA 550.1518 appeal to the courts provided for appellants has been abandoned), such a factual background borders upon the Primary Jurisdiction Doctrine, of necessity, to address the protective needs of the public and the agency itself for uniform resolution becomes crucial. Rinaldo's Construction Corp. v Michigan Bell Telephone Company, 454 Mich 65, 559 NW2d 647 (1997). The knowledgeable administrative decisionmaking of the Commissioner and the IHO are in peril of being ignored here; the Primary Jurisdiction Doctrine refuses to become a legal eunuch, especially when two opportunities for appeal were ignored by Appellants. A Declaratory Judgment Action thereby becomes a subterfuge, a device which allows an ancillary attack, rather than making Appellants grapple with the direct issues resolved by Commissioner and the IHO. Both the Court of Appeals and the Review Petition called for under 1980 PA 350 are in peril of being bypassed here.

Finally, the Court's obligation to consider the interference that judicial resolution of the issue and its adverse impact on the agency's performance will, left unchecked, invite the precise chaos which Appellants offer here. This is beyond the mere anxiety of relitigation, beyond about this being simply a "second bite at the apple". This is a broad-daylight "theft" of the apple. Whatever an administrative agency may rule or decide, by

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bringing a Declaratory Judgment action, the agency action can be negated as if the regulatory framework will be neutralized as a tabula rasa to ignore. Rather than the traditionally ordered and statutorily required appellate challenges to administrative expertise afforded by statute, Appellants offer here a bold new innovation which confounds even the most basic of all Primary Jurisdiction tenets - the dissatisfied administrative litigant may simply ignore the agency decision and sue in court as a whole new enterprise.

As indicated above, there is a solid phalanx of recent Michigan Appellate cases which instruct Bench and Bar to avoid judicial resolution of those issues which are better preliminarily concluded by the administrative process. The most important of these, certainly, was the decision of this Court last year in Travelers' Ins. Co. v Detroit Edison Co., 465 Mich 185, 631 NW2d 733 (2001) relating to exculpatory tariffs applicable in utilities regulation enforced by the Michigan Public Service Commission. Plaintiff Travelers there sought to avoid the legal effect of the Michigan Public Service Commission tariffs by filing traditional judicial damages litigation. While the primary issue in Travelers' focused upon whether or not the Primary Jurisdiction Doctrine was an "affirmative defense" capable of being waived, the Supreme Court of Michigan, through Honorable Justice Stephen Markman, did a superb history of the Doctrine, explaining its very expansive legal breadth, commencing

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with the seminal case of Texas & Pacific Ry. Co. v Abeleine Cotton Oil Co., 204 US 426, 27 S.Ct 350 (1907).

In footnote 11 of the Opinion, the Travelers' Supreme Court of Michigan also cited Communication Workers of America v Beck, 487 US 735, 743, 108 S.Ct 2641 (1988)(holding that employees may not circumvent the primary jurisdiction of the National Labor Relations Board simply by relabeling statutory claims under administrative procedures as violations of tort to be litigated in Court). Also cited by the Travelers' Court was Federal Communications Commission v ITT World Communications, Inc., 466 US 463, 468, 104 S.Ct 1936 (1984)(applying the Doctrine of Primary Jurisdiction to the FCC, holding that the case should have been dismissed when, as here, the central element of the complaint was the agencies past conduct) and San Diego Building Trades Council v Garmon, 359 US 236, 245, 79 S.Ct 773 (1959)(holding that when an activity is arguably subject to portions of an administrative act, the states and federal courts should defer to the exclusive competency of the administrative agency in order to minimize the danger of interference with the role and national policy of the administrative agency). (See Travelers', 465 Mich 185, 193-194).

Furthermore, Travelers' held recently that the ratio decendae of the Primary Jurisdiction Doctrine has inhered in the principle of Separation of Powers, clearly allocating between the Courts and legislative delegates their respective adjudicatory

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roles. Travelers', 465 Mich 185, 194-195. Travelers' also cited with approval Attorney General v Diamond Mortgage Co., 414 Mich 603, 613, 327 NW2d 805 (1982), holding that the essential justification for the Primary Jurisdiction Doctrine was the administrative agency's handling of issues and factual matters not within the conventional experience of Judges or cases, complex matters requiring the exercise of superior, knowledgeable administrative discretion. Travelers' made clear, also, that an administrative agency necessarily possesses the superior knowledge and expertise in addressing recurring issues in the scope of its authority. Travelers', 465 Mich 185, 197.

A number of other contemporaneously decided cases also ordain that the Courts generally ought to defer to the administrative decisionmaking[10] when there is demonstrably superior legislatively endowed expertise. See, for example, Diminion Reserves, Inc., v Michigan Consolidated Gas Co., 240 Mich App 216, 221, 610 NW2d 282 (2000); Durcon v Detroit Edison Company, 250 Mich App 553, 2002 WL 481354 (2002); Cherry Growers, Inc., v Agricultural Marketing & Bargaining Bd., 240 Mich App 153, 161-162, 610 NW2d 613 (2000).

Which brings us to our next point: Appellants had a four-square appellate remedy from the unfavorable Provider Class Plan

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[10] Of course judicial supervision under 1980 PA 350 is recognized at the Michigan Court of Appeals and Michigan Supreme Court level pursuant to MCLA 550.1518. Appellants chose to abandon that appeal, however. Appellants also refused even to begin the administrative appellate process called for by MCLA 550.1515 as to the final approval of the Remedial Plan on March 29, 2001. (See Attachment "E").

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decision which they abandoned despite clear MCLA 550.1518 rights to challenge the Provider Class Plan as well as the MCLA 550.1502(8) standards as modified by Blue Cross Blue Shield of Michigan and approved by the Commissioner now under attack in the Supreme Court. Appellants also indisputably had a review remedy under MCLA 550.1515 to challenge the final Remedial Plan. Again, Appellants did nothing.

When there is an administrative remedy with rights of judicial appeal recognized for a particular forum of statutory matter subject to regulatory scrutiny, the use of the Declaratory Judgment technique as an appellate alternative, even if generally available, is nevertheless highly disfavored. Consider Punohu v Sunn, 666 P2d 1133, 1134, (Haw 1983)("accordingly, we hold that the remedy of [administrative] appeal provided by [statute] is a statutorily provided special form of remedy for the specific type of case involved here and that a declaratory judgment action, pursuant to [statute] did not lie...."); Fromer v Department of Economic Development, 1996 WL 367805 (Conn 1996); Allnet Communication Service, Inc. v National Exchange Carrier Association, Inc., 965 F2d 1118 (Ca Dc 1992); Luskin's, Inc. v Consumer Protection Division, 657 A2d 788, 792 (Md App 1995); Jackson County Iron Co. v Musolf, 396 NW2d 323 (Wis 1986)(refusal of an administrative respondent to timely pursue available administrative appeals prohibits it from later seeking declaratory relief).

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When an administrative appeal exists (and here it does whether under MCLA 550.1518, MCLA 550.1515 and MCLA 24.301), and a disgruntled administrative litigant elects, instead, to pursue Declaratory Judgment litigation as an alternative to administrative appeal under MCR 2.605(A), the person seeking to avoid established appellate remedies from adversely decided administrative proceedings does so only at his or her own peril: Michigan Courts agree that such evasive Declaratory Judgment proceedings ought not to serve as a substitute for clearly recognized, statutory administrative appellate procedures, which is precisely what Appellants have done here. See, for example, CSXT Inc. v Pitz, 883 F2d 468 (6th Cir. 1989) (Michigan Law; refusing to entertain a federal Declaratory Judgment Action on abstention grounds because the Michigan Administrative Procedures Act, MCLA 24.301, et. seq., allowed for appellate presentation of the instant question); Jones v Department of Corrections, 185 Mich App 134, 138, 460 NW2d 575 (1990) (Court should not allow a Declaratory Judgment complaint to serve as an available petition of judicial review under MCLA 24.301, et. seq., in light of inadequacies of administrative record). Greenfield Construction Co., Inc. v Michigan Department of State Highways, 58 Mich App 49, 57, 227 NW2d 223 (1975)(where trial court Declaratory Judgment allowed notwithstanding administrative appellate remedies, held, reversed as improper).

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CONCLUSION

Amicus Curiae Blue Cross Blue Shield of Michigan respectfully submits to the Michigan Supreme Court that two (2) front-line sine qua non objections exist to entertaining the within appeal before the Michigan Supreme Court.

First of all, as amply demonstrated above, Appellants have abandoned a viable MCLA 550.1518 appellate remedy on the precise question when it was decided before the agency/Independent Hearing Officer. Appellants, furthermore, declined even to file a Petition for Review under MCLA 550.1515 as to the later, approved Remedial Plan. (See Attachments "F" and "G"). This effectively created a lethal Res Judicata/collateral estoppel defense which ought to be employed by the Michigan Supreme Court to negate any revisions in the Provider Class Plan, as modified by Blue Cross Blue Shield of Michigan and approved by the Commissioner, sought by this collateral attack, because the Appellants elected to avoid that judicial appellate remedy in favor of an improper, parallel, Declaratory Judgment Action. Allowing that "end run" is not only bad policy, it eviscerates the potency of MCLA 550.1518 and MCLA 550.1515. According to Appellants, if one does not like the Commissioner's decision, one may feel free to blow the recognized MCLA 550.1518 appeal in favor of a whole new Declaratory Judgment case. As Appellants see it, one may just ignore the mandated MCLA 550.1515 petition

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rights and one is "home free" to relitigate the matter to one's heart's content.

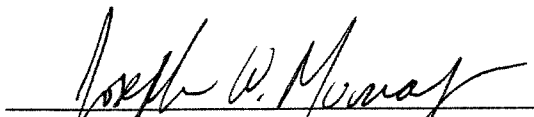
Secondly, the Primary Jurisdiction Doctrine, reflecting a distinct judicial policy preference for administrative decisionmaking, strongly militates against entertaining this case in this fashion as now before our Supreme Court. A Declaratory Judgment case, which seeks to overturn administrative findings capable of being appealed, creates a wholly unnecessary, redundant mode of relief which, simply put, trashes the intricate and very well-thought-out framework of 1980 PA 350 by auxiliary, ancillary relief not contemplated by the Legislature. Here, Appellants' Emperor wears no clothes, indeed.

There are, therefore, two (2) fundamental objections to the Supreme Court's entertaining this case at this time. These should be taken into account at the time of the decision.

Amicus Curiae therefore respectfully requests that all relief requested by Appellants in this appeal be denied as wholly inappropriate.

Respectfully submitted,

BLUE CROSS BLUE SHIELD OF MICH



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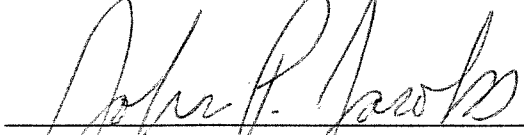

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Dated: October 28, 2002

JOHN P. JACOBS, P.C., ATTORNEYS AND COUNSELORS AT LAW • THE DIME BUILDING • 719 GRISWOLD STREET, SUITE 600 • DETROIT, MI 48232-5600 • (313) 965-1900

STATE OF MICHIGAN

IN THE SUPREME COURT
(ON APPEAL FROM THE MICHIGAN COURT OF APPEALS)

BLAKEWOODS SURGERY CENTER, LLC., JACKSON MEDICAL SERVICES, INC., PAUL ERNEST, M.D., KEVIN LAVERY, M.D., ANTHONY SENSOLI, M.D., SIGMUND ANCEREWICZ, M.D., KHAWAJA IKRAM, D.O., SHARON ROONEY-GANDY, D.O., ARTHUR WIERENGA, M.D., MARTIN PATRIAS, M.D., MICHAEL CHAMES, M.D., GHULUM DASTGIR, M.D., and KABINDRA MISHRA, M.D.,

Plaintiff-Appellants,

v.

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, in its Official Capacity

Defendant-Appellee.

Supreme Court Docket No: 118935

Court of Appeals No: 221494

Trial Court No: 98-88770-CZ

/

PROOF OF SERVICE

STATE OF MICHIGAN)
)SS.
COUNTY OF WAYNE)

LAURIE A. FULLER, being first duly sworn, deposes and says that on October 28, 2002, she caused to be served a copy of the Motion For Leave to file Amicus Curiae Brief for Blue Cross Blue Shield of Michigan and Brief of Amicus Curiae, Blue Cross Blue Shield of Michigan and this PROOF OF SERVICE upon:

Linda S. Fausey, Esq.
328 North Walnut St.
Lansing, Michigan 48933

Larry F. Brya, Esq.
Assistant Attorney General
Economic Development
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120 N. Washington Square

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Blue Cross and Blue Shield
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600 Lafayette East, #1925
Detroit, Michigan 48226

P.O. Box 30217
Lansing, MI 48909

by enclosing copies of same in envelopes with first class postage fully prepaid thereon and depositing them in the United States mail at Detroit, Michigan.

Laurie A. Fuller

Laurie A. Fuller

Subscribed and sworn to before me
this 28th day of October, 2002.

Dolores J. Bader

Dolores J. Bader, Notary Public
Wayne County, MI
My Commission Expires: 7/10/04

JOHN P. JACOBS, P.C., ATTORNEYS AND COUNSELORS AT LAW • THE DIME BUILDING • 719 GRISWOLD STREET, SUITE 600 • DETROIT, MI 48232-5600 • (313) 965-1900

Attachment "A"

STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

INSURANCE BUREAU

Before the Commissioner of Insurance

In the matter of the Ambulatory Surgical Facilities
Provider Class Plan Determination Report
pursuant to P. A. 350 of 1980
_____/ No. 00-007-BC

Issued and entered
this 20th day of March, 2000
by Frank M. Fitzgerald
Commissioner of Insurance

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to P. A. 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of Insurance (Commissioner) issued Order No. 99-117-BC on July 6, 1999, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of his intent to make a determination with respect to the ambulatory surgical facilities provider class plan for calendar years 1996 and 1997.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.

2. All applicable provisions of the Act have been complied with.

3. All procedural requirements of the Act have been met.

4. The staff reviewed relevant data pertaining to the ambulatory surgical facilities provider class plan as discussed in the attached report, including testimony received, at a public

hearing held by the Commissioner. The public hearing was designed to provide the public with an opportunity to present data, views, and arguments with respect to this provider class plan.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

III

ORDER

Therefore, it is ORDERED that:

1. The attached ambulatory surgical facilities provider class plan determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the ambulatory surgical facilities provider class plan for the calendar years 1996 and 1997.

2. Pursuant to Section 510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of such determination by certified or registered mail.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.

Frank M. Fitzgerald
Commissioner of Insurance

AMBULATORY SURGERY FACILITIES

PROVIDER CLASS PLAN

DETERMINATION REPORT

for the calendar years 1996 and 1997

Michigan Insurance Bureau

State of Michigan

AMBULATORY SURGERY FACILITIES

PROVIDER CLASS PLAN

DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to the nonprofit health care corporation reform act, Public Act 350 of 1980 (Act), this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Act for calendar years 1996 and 1997. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 1996-1997 ambulatory surgery facilities (ASF) provider class plan annual report, additional data requested of BCBSM, information submitted by the public and information on file with respect to this provider class plan. This material was supplemented as necessary by data from published sources. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balancing among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to certificate-covered ASF services whenever necessary. In analyzing BCBSM's performance on the access goal, BCBSM members did not have reasonable access to ASFs during the two-year period under review. This determination is primarily based on the fact that BCBSM achieved a formal participation rate of only 36% throughout the state.

This determination also took section 502(8) of the Act into account which states "A health care corporation shall not deny participation to a freestanding surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities..." BCBSM's standards for participation were found to be unreasonable. In addition, BCBSM did not uniformly apply its standards.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for ASFs, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. It was determined that BCBSM did not meet the statutory goal for calendar years 1996 and 1997.

BCBSM did not meet the quality of care goal for three reasons. BCBSM does not review or re-certify ASFs once participation is granted. BCBSM's audit process for ASFs is deficient because it fails to address quality issues. BCBSM also did not communicate its quality standards clearly to providers.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of a cost formula specified in the Act, which is estimated to be 3.9% for the period under review. The rate of change in the total corporation payment per member for the ambulatory surgery facilities provider class has been calculated to be an increase of 3.4% over the two years being reviewed, therefore BCBSM met the cost goal stated in the Act for 1996 and 1997.

Overall Balance of Goals

In summary, BCBSM did not substantially achieve two of the three statutory goals for the ASF provider class plan for the two-year period under review. A new provider class plan is required because it has been determined that BCBSM's failure to achieve these goals was not reasonable. Within six months, BCBSM must submit a new ASF provider class plan that substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the findings section in this determination report.

Determination Report
Order No. 00-007-BC

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) meets the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act (Act) with respect to the ambulatory surgery facilities (ASF) provider class plan for the calendar years 1996 and 1997.

In addition to the final determination, this report will define a provider class plan, explain the statutory and review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings which support that determination.

Provider Class Plans - Legal Background

Section 107(7) of the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), defines a provider class plan as "a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act. It should be noted that, pursuant to the Act, the nonprofit health care corporation establishes provider classes.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers may include not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for services provided to a BCBSM member.

2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.

3. BCBSM must compensate providers in accordance with reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each

provider class that is not higher than the compound rate of inflation and real economic growth.

Section 509(4) of the Act requires the Commissioner of Insurance (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM that pertain to each respective provider class;

2. Oral and written testimony received from subscribers, providers, and provider organizations;

3. Health care legislation;

4. Demographic, epidemiological and economic trends;

5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations pursuant to Section 510(1) of the Act:

(a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.

(c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the

findings. If after six months BCBSM fails to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the Ambulatory Surgery Facilities Provider Class Plan

The following description of BCBSM's ambulatory surgery facilities provider class plan is taken from BCBSM's *Guide for Ambulatory Surgery Facilities* and the ASF provider class annual report.

> The Ambulatory Surgery Facilities provider class plan includes freestanding, outpatient surgery facilities excluding physicians' offices, other private practice offices, and surgical outpatient facilities owned by and operated as part of a hospital, unless it is licensed by the state as a freestanding Surgical Outpatient Facility.

Ambulatory surgical facilities are subject to certain qualification standards set by BCBSM. BCBSM states that these include, but are not limited to:

- Licensed by the State of Michigan as a Freestanding Surgical Outpatient Facility.
- Provide ambulatory surgery in at least five of the following surgical categories: Integumentary, Musculoskeletal, Respiratory, Cardiovascular, Digestive, Urinary, Male Genital, Female Genital, Nervous, Eye/ocular addenda, and Auditory.
- Accreditation by at least one of the following national organizations: Joint Commission on Accreditation of Health Care Organizations (JCAHO), American Osteopathic Association, and Accreditation Association for Ambulatory Health Care (AAAHC).
- Have Medicare certification as an ambulatory surgery center.
- Meet BCBSM evidence of necessity requirements.
- All patients admitted to the ASF must be under the care of a licensed medical doctor, doctor of osteopathy or podiatry.
- Have an organized medical staff to maintain proper standards of medical care.
- Must have a written agreement with at least one acute-care general hospital. The hospital must be located near enough to the facility to enable the prompt transfer of patients requiring hospital care.
- The ASF must develop and implement utilization management and peer-review programs that: assess the quality of care provided to patients to ensure that proper services are provided at the proper time by qualified individuals, identify, refer, report and follow up on quality-of-care issues and problems and monitor all aspects of patient-care delivery.

- The ASF must also have a utilization-management and peer-review plan that identifies purposes, goals, mechanisms and personnel responsible for all parts of the plan, including: quality, content and completeness of medical records, clinical performance, quality and appropriateness of diagnostic and treatment procedures, evaluation of tissue specimens, medication utilization, patient satisfaction, quality and appropriateness of anesthesia and arrangements for patients requiring hospitalization following ambulatory surgery.

There are several services listed under the ASF provider class plan. Those services that can be safely performed without requiring overnight hospital care include:

- Use of ambulatory surgical facility that includes operating, recovery, or other treatment rooms, pre-operative areas, patient preparation areas, post-operative areas used by the patient or offered for use to the patient's relatives in connection with surgical procedures.
- Medical-surgical supplies directly related to the surgery provided, such as the following: biological (such as vaccines), surgical dressings, supplies, splints, casts, and intraocular lenses.
- Drugs.
- Oxygen and other therapeutic gases.
- Materials for anesthesia.
- Administration of blood.
- Routine laboratory services related to the surgery or a concurrent medical condition.
- Radiology services performed with equipment owned by the facility or performed on the premises of the facility. Services must be necessary to perform the surgery.
- Housekeeping supplies and services.
- Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissues as well as the costs of processing and storage.
- Nursing care provided by or under the supervision of a registered nurse.

For the purposes of this report, the above-indicated services are collectively referred to as ambulatory surgical services. These services are available to BCBSM members as long as the services are performed in a participating ASF. Those services obtained in ambulatory settings that do not formally participate with BCBSM are not covered services. In areas in which there is no participating ASF, services can be provided in a hospital outpatient setting and many services can also be performed in a physician's office.

In 1997, payments to ASF providers represented less than 1% of the total benefit payments made to health care providers on behalf of BCBSM members. For the purpose of provider class plan reviews by the Insurance Bureau, paid claims data is categorized into nine geographic regions. A map depicting these geographic regions is included as Attachment A to this determination report.

BCBSM's reimbursement policies are as follows:

For ambulatory services, BCBSM uses a price-based payment system based on the lower of the facility's charge or BCBSM's procedure-specific price for a covered service. In a situation where there is insufficient data to develop a price-based payment for a procedure, a cost-based system is used.

The price based payment method is driven by two components:

- Payment unit = HCFA Common Procedure Coding System (HCPCS) code
- Payment level = Pricing formula

The payment unit refers to surgery related activities while the payment level for each HCPCS code is determined by the pricing formula.

BCBSM also uses two other reimbursement methods in rare cases. The nominal price-based payment is for surgical procedures that are predominantly performed in a physician's office. When these procedures are performed in an ambulatory setting, the ASF receives a nominal price-based payment, which is limited to a minimum dollar amount per surgical procedure.

The statewide percentage of charge payment is based upon an initial ratio of charges to total charges applied to cost. This method is only used for two categories of services: cancellations that occur on the day of surgery and selected outpatient surgical services with minor statewide utilization.

Outpatient surgical procedures are reimbursed on a claim-by-claim basis. BCBSM does not make interim payments to ASF or conduct year-end cost settlements.

BCBSM is required to include, as part of each provider class plan, its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the ASF provider class plan are as follows:

Access:

- To ensure appropriate access to ambulatory surgery, BCBSM will participate with ambulatory surgery facility providers in those communities that demonstrate need for additional ambulatory surgery room capacity.

Quality of Care:

- To ensure provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for ambulatory surgery facility participation.

Cost:

- To strive toward limiting the increase in the total payments per member for ambulatory surgery facilities to the compound rate of inflation and real economic growth as specified in Public Act 350, giving special consideration to Michigan and national health care market conditions.

- To provide equitable reimbursement to ambulatory surgery facilities in return for high quality services which are medically necessary and delivered to BCBSM subscribers at a reasonable price.

History of the Ambulatory Surgery Facilities Provider Class Plan

BCBSM had an existing reimbursement arrangement with ASFs in effect when the Act took effect on August 27, 1985. On February 16, 1987, BCBSM first filed with the Insurance Bureau its ASF provider class plan pursuant to Section 506(1) of the Act. Section 506(2) states:

"Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."

Section 506(2) further states:

"For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the ambulatory surgery facility provider class plan met the filing requirements of Section 506 of the Act stated above, the Bureau notified BCBSM by letter on February 13,

1987 that the ambulatory surgery facility provider class plan was placed into effect and retained for the commissioner's records pursuant to Section 506(4).

Several modifications were made subsequent to the first filing.

The first change to the plan was to modify the appeal process on November 5, 1987.

BCBSM filed a modified provider class plan on November 17, 1992. Revisions made to the provider class plan included a revised evidence of need (EON) process in which ASFs needed to meet a specific equation dealing with need. The revision also included a contract revision.

In May 1993, BCBSM issued an erratum sheet and a revised version of its reimbursement policies. However, none of the corrections, clarifications or revisions substantively changed the meaning of the contract.

In February 1995, BCBSM filed revised provider contracts for the ambulatory provider class. The contract was revised to reflect BCBSM's participation in the Inter-plan Teleprocessing Systems and the requirements of the BCBS Association.

BCBSM once again changed the appeals process on June 21, 1996.

BCBSM modified the provider class plan again on September 2, 1997 by eliminating its qualification standard that facilities show evidence of adequate professional liability and comprehensive general liability insurance with a licensed insurance company or self-funded insurance.

In October 1997, BCBSM filed modified provider class plans for M.D.s, D.O.s, nurse specialists and ASFs. This revision reflected the termination of the West Michigan Anesthesia Pilot Program and incorporated a new reimbursement methodology for anesthesia services and direct reimbursement of certified registered nurse anesthetists. This revision went into effect on April 1, 1998.

All non-hospital, non-physician provider class plans, including the ASF provider class plan, were revised in December 1997 to include another revised appeals process. The parts of the process that changed included only the addresses where providers need to submit their requests for review. This revision was filed by BCBSM on December 8, 1997.

Review Process

On July 6, 1999, the Commissioner issued Order No. 99-117-BC, which provided written notice to BCBSM, health care providers, and other interested parties of his intent to make a

determination with respect to the ambulatory surgery facilities provider class plan for the calendar years 1996 and 1997. Order No. 99-117-BC also called for any person with comments on matters concerning the provider class plan to submit such comments to the Insurance Bureau in accordance with Section 505(2) of the Act. Section 505(2) requires the Commissioner to establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. A notice of hearing was attached to the order stated above scheduling a public hearing on Wednesday, August 23, 1999 at the offices of the Insurance Bureau, thus giving interested parties a reasonable amount of time in which to prepare testimony.

Summary of Testimony and Input:

Susan M. Scarane of the Insurance Bureau staff conducted the public hearing. In attendance were representatives from BCBSM, the Michigan State Medical Society, Michigan Health and Hospital Association (MHA) and doctors and administrators of various ASFs and their counsel. Written testimony was also accepted and incorporated as part of the hearing record. An extensive summary of the testimony submitted as part of the hearing record is included as Attachment B.

The main issues taken from the testimony include: physician owned ASFs stated BCBSM's EON process is not reasonable nor is it applied uniformly. These ASFs also testified that the five-specialty requirement limited access to participation and also had a negative effect on quality of care.

BCBSM and the MHA both submitted testimony in support of BCBSM's achievement of all three statutory goals.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1)(a) of the Act states "There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to ambulatory surgery facilities services covered under the terms of that member's certificate. In analyzing BCBSM's performance on the access goal, several aspects of how access to ASF services could be obtained were examined. This included formal participation rates of providers to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

The following information, supplied by BCBSM to the Insurance Bureau in August 1999, shows the number of participating ASFs by geographic region for calendar years 1996 and 1997 as follows:

Ambulatory Surgical Facilities Provider Class Plan
Formal Participating Rate
Includes only Eligible* Providers

	1996			1997		
	Participating Providers	Total Eligible Providers	Participation Rate	Participating Providers	Total Eligible Providers	Participation Rate
Region 1	13	24	52.20%	12	23	52.20%
Region 2	0	0	0.00%	0	0	0.00%
Region 3	0	2	0.00%	1	3	33.30%
Region 4	0	2	0.00%	1	3	33.30%
Region 5	1	4	25.00%	2	5	40.00%
Region 6	2	4	50.00%	2	4	50.00%
Region 7	2	2	100.00%	2	2	100.00%
Region 8	0	1	0.00%	0	1	0.00%
Region 9	0	1	0.00%	0	1	0.00%
Toledo, OH	1	1	100.00%	1	1	100.00%
Statewide	19	41	46.30%	21	43	48.80%

* Eligible = Meets BCBSM quality requirements for five areas of surgical care (excludes EON)

As shown in the above table, BCBSM states that formal participation rates for ASFs increased from 46.3% in 1996 to 48.8% in 1997. These rates are calculated including only ASFs that meet BCBSM requirements for participation and provides five areas of surgical care. Therefore, these numbers are somewhat misleading in terms of BCBSM's actual participation rates with all ASFs. BCBSM also included Toledo, Ohio in its formal participation rates. While it is true that some Michigan patients may visit the ASF in Toledo, it cannot be included in determining whether BCBSM has met the access goal of an appropriate number of providers "throughout this state." The 100% participation rate in Toledo acts to artificially inflate BCBSM's participation rates within Michigan.

BCBSM states in its ASF provider class plan annual report that the total number of licensed providers are estimated because the data obtained from the Michigan Department of Community Health does not make the distinction between ASFs that meet the five areas of surgical care and those that do not.

Since BCBSM's data did not include all ASFs in the state, BCBSM was requested to provide the Insurance Bureau with a revised participation table including all ASFs in the state of Michigan in order to correctly analyze BCBSM participation rates. When all ASFs in the state are included, the figures below indicate that participation rates were 35.8% and 35.6% for 1996 and 1997, respectively. BCBSM participation rates for 1996 and 1997 were actually 34.6% and 36.2%, respectively when the Toledo ASF is excluded from the calculation.

Ambulatory Surgical Facilities Provider Class Plan
Formal Participating Rate
Including All Licensed Providers

	1996			1997		
	Participating Providers	Total Licensed Providers	Participation Rate	Participating Providers	Total Licensed Providers	Participation Rate
Region 1	13	28	46.40%	12	30	40.00%
Region 2	0	1	0.00%	0	1	0.00%
Region 3	0	4	0.00%	1	5	20.00%
Region 4	0	2	0.00%	1	4	25.00%
Region 5	1	7	14.30%	2	7	28.60%
Region 6	2	5	40.00%	2	5	40.00%
Region 7	2	2	100.00%	2	2	100.00%
Region 8	0	1	0.00%	0	1	0.00%
Region 9	0	2	0.00%	0	3	0.00%
Toledo, OH	1	1	100.00%	1	1	100.00%
Statewide	19	53	35.80%	21	59	35.60%

There seemed to be several access issues in conflict among BCBSM and providers. BCBSM contends there is adequate access to ambulatory and outpatient care for its subscribers. Physician owned ASF providers argue that there is not sufficient access for patients to ambulatory care because BCBSM does not participate with enough ASFs throughout the state. Therefore, providers assert BCBSM does not ensure that BCBSM members have reasonable access to providers in any given area of the state to assure the availability of certificate-covered services as the statute requires. This analysis looks at access as a concept that includes convenience of geographic location, ease and accessibility on site, quality of care, patient choice of provider and dollar value to the subscribers rather than provider accessibility to patients.

In addition to lack of participating facilities in certain areas of the state, it appears the main access issue regarding ASFs involves whether BCBSM is fairly applying its criteria to permit freestanding ASFs to participate with BCBSM. Providers testified that during the review period BCBSM participated with only one freestanding ASF, Lansing Surgery Center (formerly Greater Lansing Ambulatory Surgery Center Company) in which participation was ordered by the Wayne County Circuit Court[1]. The court's ruling has since been reversed by the Michigan Court of Appeals[2], but BCBSM has permitted the facility to remain a participating provider.

BCBSM claims that it participates with three physician owned ASFs: Lansing Surgery Center, Health Care Midwest (formerly Reconstructive Surgery) and the Toledo Clinic. Once again, despite the fact that some patients in southeast Michigan may visit the Toledo Clinic, this data cannot be included in the analysis since it is outside of Michigan. Reconstructive Surgery was a physician owned ASF that was granted participation in 1993. No EON calculation was done after the clinic changed names. BCBSM was unable to supply an original EON calculation sheet for Reconstructive Surgery.

When looking at BCBSM participation rates, it appears that there is not "an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber," as required in Section 504(1)(a) of the Act. BCBSM participates with ASFs in 11 of Michigan's 83 counties. ASFs currently exist in 17 counties across the state.

The data shown above for 1997 illustrates that BCBSM does not participate with any ASFs in regions 2, 8 or 9. Regions 8 and 9 represent a large portion of northern Lower Michigan and the entire Upper Peninsula. Providers testified that this demonstrates a clear lack of access since BCBSM does not participate with any of the three ASFs in the Upper Peninsula. BCBSM states that, in the absence of a participating ASF, members are able to receive outpatient surgery in a hospital setting, or in many cases, a physician's office.

BCBSM offers the argument that access is measured by access to certificate covered benefits and not by provider type. BCBSM is correct in the fact that members can obtain services from hospital outpatient settings and in many cases in a physician's office. However, this analysis is a review of the ASF provider class. ASFs were determined by BCBSM to be different enough to warrant a separate provider class plan. BCBSM subscribers should therefore have choices in the type of setting they wish to get outpatient surgery. BCBSM argues that in previous determination reports for hearing specialists and rehabilitation therapy, it was noted that access to covered services under one plan is not compromised if BCBSM's members obtain the services under another provider class plan.

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1 Wayne County Circuit Court, Greater Lansing Ambulatory Surgery Center Company versus BCBSM, docket # 96-635927-cz.

2 The Court of Appeals, Greater Lansing Ambulatory Surgery Center Company versus BCBSM, docket # 206415.

This position was warranted under the specific facts of those plan's reviews. However, the ASF plan is different. In the hearing specialists and rehabilitation therapy provider class plans, participation rates were slightly low (60-90%) whereas the participation rates in the ASF provider class plan are very low with a rate about 36%. In some cases, such as Northern Michigan and the Upper Peninsula, the ASF participation rate is 0%. The subscriber's only option is to receive care from hospitals or physician's offices. The Act discusses access in terms of services as opposed to provider type. However, if multiple provider types are able to render the same or similar services there should be some balance in the type of providers BCBSM contracts with to provide such services. This is obviously not the case since BCBSM does not participate with any ASFs in the northern portion of the state.

Many providers testified that BCBSM participation guidelines are too restrictive. One reason given was that the state already forced ASFs to meet state certificate of need (CON) guidelines before it could open its doors to the public. A freestanding surgical facility must receive a CON to operate and also be certified by Medicare in order to participate with BCBSM.

Prior to 1996, the State's CON required that any ASF proposing to open a surgical room had to demonstrate that each proposed operating room shall perform an average of at least 1,000 surgical cases per year per operating room by the end of the second full year of operation.

In January 1996, the State changed the CON criteria that had been in effect since November 20, 1989. The new CON required ASFs to demonstrate that the room would perform at least 1,200 surgical cases or have 1,800 hours of use per year per operating room in the second year of operation and annually thereafter.

To substantiate that 1,200 cases will be performed annually, ASFs may use surgical cases from existing operating rooms (OR) that are performing above the 1,200 minimum or surgical procedures currently performed in a physician's office (that are actually more likely to be done in an OR). Both avenues must be accompanied by commitments from physicians. Each physician's commitments must be accompanied in hardcopy and on diskette by a chronological listing of procedures/cases--including a confidential patient identifier, CPT code, description of procedure, and geographic location of where procedure or case was performed. Additionally, cases that physicians commit to from an existing OR cannot cause the surgical facility to fall below the required minimum of an average of 1,200 cases per OR.

Providers testified that the CON already determines whether there is an unmet need in the area. BCBSM contends its EON does not conflict or duplicate the CON, but rather is particular to its own members and not for the entire general population.

Prior to 1996, the State did not take into account the marketplace into which the proposed facility wished to locate. The CON guidelines addressed only the number of procedures that the physician owners had committed to, and an analysis of the finances and capital resources necessary to construct the facility. Starting in 1996 the State did begin to analyze whether there was an unmet need for surgical services.

Some providers testified that BCBSM should not be able to refuse payment simply because a service is rendered by a non-participating provider. In essence these providers are asserting that BCBSM must reimburse any provider possessing a license by the state of Michigan for any service listed in its certificates of coverage. Providers also testified that BCBSM oversteps its statutory authority because its EON process serves as a licensure activity.

However, the Act is fairly clear that BCBSM has the right to impose its own requirements.

> Section 107(1) of the Act states "'Participating provider' means a provider that has entered into a participating contract with a health care corporation and *that meets the standards set by the corporation for that class of providers.*"
>
> Section 105(4) of the Act states "'Health care provider' or 'provider'...means a health care facility; a person licensed, certified, or registered under parts 161 to 182 of Act No. 368 of the Public Acts of 1978, as amended, being sections 333.16101 to 333.18237 of the Michigan Compiled Laws; any other person or facility, with the approval of the commissioner, *who or which meets the standards set by the health care corporation for all contracting providers....*"
>
> Section 502(3) of the Act states "A health care corporation shall not restrict the methods of diagnosis or treatment of a professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or *to standards set by the corporation for all contracting providers....*"

The Act states in Section 502(8) that BCBSM does in fact have the right to set "reasonable standards" for provider participation. Therefore, the question becomes whether the EON criteria set by BCBSM is reasonable.

BCBSM is allowed to set standards for participation and is not obligated to reimburse every state licensed ASF. However, the standards that BCBSM employs must be reasonable and are subject to review by the Commissioner.

BCBSM uses EON as a methodology for determining sterile surgical facility needs in a given geographical area. BCBSM's current EON formula is outlined in Attachment C. The EON formula used during the review period is outlined in Attachment D. ASFs must meet both the state's CON and BCBSM's EON requirements in order to participate with BCBSM. BCBSM began formally applying its own EON criteria in September 1993.

The EON needs to be analyzed for the reasonableness of its criteria and also whether BCBSM is applying them reasonably and uniformly.

The EON counts all inpatient and outpatient surgical procedures and operating rooms. Including inpatient surgical procedures and operating rooms in the EON calculation serves to skew the results given that the ASF provider class plan deals strictly with outpatient surgical procedures. Unfortunately, the Michigan Department of Community Health (MDCH) has stated that although a complete breakdown of inpatient and outpatient surgical procedures would be possible, it would not likely be accurate. As it stands, MDCH currently knows the number of licensed inpatient beds at each hospital, how many emergency room visits resulted in inpatient admissions and how many emergency room visits ended up as discharges. MDCH cannot, however, break down data by inpatient surgery and outpatient surgery.

By counting all operating rooms, the EON standard really measures the need for all surgery rooms rather than just freestanding surgery rooms. Further, hospitals do not need to meet BCBSM's EON criteria to add operating rooms in the hospital setting. The inclusion of hospital surgery rooms dilutes the EON formula and makes it nearly impossible for non-hospital owned ASFs to meet the EON. Hospitals only need to meet CON in order to add an operating room. Therefore, whenever a hospital adds an operating room, the capacity for surgery increases making it more difficult for physician owned ASFs to demonstrate that there is a need in the community for its services. Even in cases where the ASF may be doing over 1,200 surgical procedures per operating room, the number of operating rooms in the hospital affect the formula enough to still show a lack of need for other ASFs. Some testified that this is the case in Grand Rapids where underutilized hospital operating rooms dilute the EON formula, making it impossible for freestanding ASFs to meet the EON. Kent County, according to BCBSM, currently has an over capacity of 17 operating rooms (See Attachment E). Yet, hospital owned ASFs are allowed to add surgical rooms any time that the hospital decides to transfer one of its rooms to an ASF.

There appears to be a conflicting nature to BCBSM's EON criteria, which needs to be examined in light of the requirements of Section 502(8) of the Act. It appears that BCBSM did not apply the EON criteria uniformly to both hospital and physician owned ASFs.

First, several hospital-owned ASFs were granted participation status by BCBSM without having to meet the EON criteria at all. These hospitals were grandfathered in between late 1992 and August 31, 1993. The hospitals are:

Blodgett Surgical Center
Grace Hospital Ambulatory Surgery Center
Horizon Surgical Center
Hutzel Health Center
Madison Community Hospital Surgical Center
Oakwood Healthcare Center
Providence Hospital Surgical Center - Novi
Providence Hospital Surgical Center - Southfield
Saginaw General (merged with St. Luke to become Covenant)
Sinai Surgery Center
Waterford Ambulatory Surgery Center.

BCBSM points out that these hospital owned ASFs were grandfathered in because before 1992, they were paid under the Participating Hospital Agreement. Hospital owned ASFs have been required to sign a separate ASF participating agreement since 1992. Since these ASFs had already been serving BCBSM members for a number of years and the fact that these ASFs would receive lower reimbursement rates under the ASF provider plan, their reimbursement was changed to the ASF plan. BCBSM contends that this lowered the cost of ambulatory surgical care and did not result in an increase in operating rooms.

BCBSM points out that there are two hospital owned ASFs in the state that do not participate with BCBSM: Henry Ford and Bronson Outpatient Surgery – Crosstown. However, further review of these situations reveals that covered services provided to BCBSM members at these hospital outpatient departments are still reimbursed by BCBSM through the Participating Hospital Agreement.

Another inconsistency in BCBSM's application of the EON involves differences in the definition of a service area.

BCBSM states that service areas are usually counties. In files obtained by the Bureau, this was found to be true in most cases. However, in the case of the Borgess Medical Center ASF in Portage, BCBSM used different criteria. In its EON calculation BCBSM used three surrounding counties, Cass, St. Joseph and Van Buren in the EON equation (See Attachment F). Although the county of Kalamazoo showed that there was no need for

additional surgery facilities (See Attachment G), BCBSM granted Borgess EON approval due to the surrounding counties' needs.

There are a couple discrepancies in how BCBSM's EON calculation for Borgess was made. First, BCBSM does not include Kalamazoo County in the EON calculation even though this is where the ASF is actually located. Second, the EON worksheet calculated for Kalamazoo County showed 41 operating rooms with an estimated need for 18 operating rooms. This was an over capacity of 22 operating rooms. A look at the actual data for Borgess Medical Center showed an excess capacity of 11 operating rooms in Kalamazoo County.

In addition to using three additional counties in the EON calculation and not using the county that the ASF was actually located in, BCBSM also subtracted inpatient rooms used for emergency and trauma. Subtracting rooms for emergency and trauma appears to be a reasonable practice, however, this adjustment must be consistently applied to all EON calculations. (Borgess is the only case known in which the EON was calculated this way.)

BCBSM used surrounding counties in this instance. It would appear to be logical that surrounding counties would also be used in cases such as the Upper Peninsula. In these cases BCBSM used only the county as a service area despite the fact that the Upper Peninsula is more rural in nature. While using the three surrounding counties seems to be advantageous in the Borgess case, it shows the degree of subjectivity that BCBSM applies to the EON and demonstrates that the EON is simply not a rigid arithmetic formula but rather one subject to manipulation. An easily manipulated standard is not a reasonable standard.

Review of these documents also shows that BCBSM was concerned that denying Borgess participation status would be an "adverse business decision from a providers relations perspective." This concern stemmed from the fact that BCBSM had recently purchased land for its Kalamazoo office directly adjacent to Borgess Medical Center's Woodbridge ASF. This further illustrates the subjective nature of the EON.

Furthermore, Jackson Outpatient Surgery Center that is owned by Jackson Foote Hospital was allowed to open five operating rooms even though Jackson Foote Hospital only closed down four operating rooms. BCBSM's EON criteria allow hospitals to transfer rooms to outpatient facilities, but the EON stipulates the transfer cannot result in additional operating room capacity in the service area. In this case, however, the hospital-owned Jackson Outpatient Surgery Center was allowed to open an operating room without having to meet the EON for the extra room. BCBSM stated in its November 5, 1997 letter to Jackson Foote Hospital that it was allowed to do this because Jackson Outpatient Surgery Center "is an endeavor where a lower cost, quality health care alternative results. Although there

is not a direct one-for-one operating room trade-off, BCBSM agrees that Foote Hospital provides a significant amount of services to the prison population."

Section 502(8) of the Act states "A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities." BCBSM holds freestanding ASFs to a different standard than those that are hospital owned, which has caused it to deny participation to physician owned ASFs while granting participation status to similar hospital owned facilities. Hospitals are able to control the number of operating rooms in a service area since they are not subject to the EON criteria. This has allowed a level of horizontal integration. Hospitals can act to prevent competing interests in the form of physician owned ASFs from gaining par status with BCBSM by essentially controlling the amount of operating rooms in a service area.

BCBSM contends that allowing the transfer of operating rooms is appropriate. BCBSM points out that the new CON requires ASFs to demonstrate from where its procedures will come. BCBSM testified that this is not a discriminatory practice toward physician owned ASFs and that BCBSM would participate with any physician owned ASF proposing a transfer of rooms. While the transfer of rooms in itself is not a discriminatory practice, BCBSM's EON inherently keeps physician owned ASFs from meeting BCBSM participation criteria. BCBSM says it will participate with physician-owned ASFs proposing a transfer, however, this would never happen because physician owned ASFs have no such rooms to transfer. A hospital would never trade rooms with a physician-owned ASF, because it would cause the hospital to lose the revenue generated by these operating rooms. It is understood that a hospital should be able to transfer rooms into a freestanding facility, however, since hospitals are not governed by the EON, they inherently control need in service areas. This has allowed hospitals to horizontally integrate and control the EON formula and to a degree, the ambulatory surgery market.

Another example of the arbitrary nature of the EON process that BCBSM employs is demonstrated in the case of Genesis Surgery Center. According to BCBSM's figures data based on the 1996 Michigan Department of Community Health's Annual Hospital Statistical Questionnaire, the number of procedures in Ingham County, including endoscopic and cystoscopic procedures, were 53,478. Using BCBSM's published EON formula for 1997, the year in which Genesis Surgery Center applied for participation, the demand for operating rooms should be 54 (.1*53,478). However, BCBSM, in a spreadsheet submitted to the Bureau, listed the demand at 45. BCBSM used 1,200 procedures per operating room as the threshold in this spreadsheet despite the fact that it did not switch to the 1,200 procedures per room until January 1998, one year after Genesis applied for participation. According to the statistics, there were 52 existing rooms. Therefore, there was a demand for two additional operating suites, but BCBSM informed Genesis that it did not meet the

EON criteria. According to the statistics and BCBSM's EON criteria, BCBSM should have agreed to participate with Genesis and allowed two operating rooms.

Given that ASFs are already required to meet the State's CON, physician-owned ASFs contend BCBSM's EON criteria is unreasonable and burdensome. For example, the Superior Endoscopy Center was granted a CON by the Michigan Department of Community Health as it was determined that there was an unmet need in the Upper Peninsula. Even though there are no other participating ASFs in that area of the state, BCBSM contends that the Superior Endoscopy Center did not meet its EON criteria. While it has been established that BCBSM has the right to set "reasonable standards," the Upper Peninsula's ASFs are an example of the unreasonable nature of BCBSM's EON criteria. BCBSM does not participate with any of the four ASFs located in Northern Michigan and the Upper Peninsula.

Many providers testified that upon being denied participation status, BCBSM only provided a denial letter and did not include any of the calculations needed to determine EON. The Insurance Bureau requested letters and files used by BCBSM to deny participation to ASFs. The letters sent to individual ASFs did not include any calculations or justification other than the fact that the ASF did not meet BCBSM's EON. The Insurance Bureau did receive BCBSM's individual files of each ASF after repeated requests. These files did include the data and spreadsheets used to calculate EON for most ASFs.

In addition, BCBSM contends that an increase in physician-owned ASFs would result in increased utilization because physicians would begin referring patients to their own facilities. BCBSM claims that the EON process is designed to prevent physician referrals to clinics in which they had a financial interest, which the Michigan Court of Appeals ruled to be illegal in Indenbaum v Board of Medicine[3]. BCBSM states that overutilization is its main concern. BCBSM also cites its own informal study indicating that these types of referrals have been made. Unfortunately, BCBSM provided no data to support its conclusions.

BCBSM's concern with overutilization is valid. However, the same concerns could be applied to physicians employed by those hospital systems that refer patients to receive outpatient surgery at their own clinics. Therefore, the EON does not seem to prevent overutilization in this respect. Furthermore, BCBSM has not been granted any regulatory authority to act as a police "watchdog." There are federal anti-kickback laws as well as the Stark self-referral laws that act to regulate providers and prevent overutilzation by self-referral. If BCBSM suspects illegal activity, it can refer such matters to the appropriate regulatory body.

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3 Indenbaum v Michigan Board of Medicine, 213 Mich App 263 (1995).

BCBSM's EON calculation is only done when an ASF applies for participation. If the ASF is granted participation, EON for that ASF is not calculated again unless there is an addition of rooms or change in ownership. This also seems to be the case with the State's CON guidelines. Once an ASF is granted CON, calculations are not done again unless there are additional ORs added or changes in ownership occur.

The problem with this practice is that changes in demographic characteristics and members needs are not taken into account on a regular basis. Population shifts and geographic needs change and should be taken into account. The Bureau obtained preliminary State CON data for 1998 for 30 different ASFs across the state. The list included hospital and physician owned ASFs. It also included many ASFs that do not currently participate with BCBSM. The number of operating rooms and surgical cases were analyzed in order to ascertain whether ASFs were meeting CON guidelines of 1,200 surgical cases per operating room. Our data outlined in Attachment H shows that only five ASFs (Blakewoods, Jackson Outpatient Surgery Center, Providence Medical Center, Health Care Midwest Surgery Center and Butterworth Health Pavilion – South) met the 1,200 cases per room guidelines. There were four additional ASFs fairly close to meeting the guidelines as well. Since BCBSM also expects participating ASFs to perform 1,200 procedures per operating room, these findings are significant because it demonstrates that very few participating ASFs are performing at a level that BCBSM expects for its members.

BCBSM requires participating ASFs to provide ambulatory surgery in at least five surgical categories. BCBSM states that through shared human and capital resources, ASFs benefit more from economies of scale with the five-category requirement. Furthermore, BCBSM adds that health care costs are better controlled through its requirement and that this is a "reasonable standard of quality" as it is implied in the Act.

ASFs argue that the surgical category requirement, although stated as a quality indicator by BCBSM, acts to limit access. ASFs contend that BCBSM uses the categories as a tool to further discriminate against ASFs. Providers contend that this requirement is unreasonable and prevents the creation of "centers of excellence." ASFs also contend that hospitals already have "centers of excellence" such as cardiac care centers. ASFs argue that the five-category requirement is merely an arbitrary requirement designed to exclude non-hospital ASFs and is not based on quality evidence. Furthermore, ASFs state that Blue Cross Blue Shield plans in many other states recognize ASFs that provide less than five different types of surgery.

ASFs also argue that this requirement actually increases health care costs for both ASFs and subscribers because each type of surgery requires different equipment and sterilization levels. For example, gastroenterologic procedures do not require the same level of sterility as general surgical procedures. Therefore rooms must be set up

specifically for one type of surgical procedure. ASFs contend that this hardly illustrates economies of scale.

The five areas of surgical care appear to only be controversial to ASFs with only one area of surgical care such as eye specialists and endoscopic centers.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered ambulatory surgical care, whenever such services are required. Based on all of the information analyzed during this review, it is determined that BCBSM did not meet the access to care goal stated in the Act for calendar years 1996 and 1997 and that such failure was within BCBSM's control. This decision is based on the following factors:

- BCBSM's participation rate with eligible ASFs was less than 50%. When all ASFs across the state are included, the participation rate is less than 36%. Section 504(1)(a) of the Act explicitly states, "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber." BCBSM mentions that certificate-covered services can be performed in a hospital outpatient setting and many times in a physician's office. However, BCBSM owes it to its members to provide a reasonable amount of choice and balance of both providers and setting. Participation rates with ASFs are much too low across the state. In fact BCBSM does not participate with any ASFs north of Saginaw County. This clearly indicates that BCBSM is not providing members with adequate access to ambulatory surgical facilities.

- BCBSM does not use reasonable standards in applying EON criteria, nor does it apply them consistently which acts to limit access for BCBSM members. Section 502(8) of the Act states "A health care corporation shall not deny participation to a freestanding medical or surgical outpatient facility on the basis of ownership if the facility meets the reasonable standards set by the health care corporation for similar facilities...." The EON criteria are almost impossible for non-hospital owned ASFs to meet. BCBSM calculates EON by using all operating rooms and all procedures in a county. Hospitals are allowed to add operating rooms without meeting EON. Hospitals are also allowed to transfer operating rooms to outpatient facilities, which acts to dilute the need for operating rooms within the service area.

- BCBSM does not consistently apply the criteria used to compute EON. The Borgess Surgi-Center at Woodbridge Hills was given preferential treatment. BCBSM used surrounding counties to calculate the EON (a practice that was unprecedented), subtracted emergency rooms used for trauma from the EON calculation and granted

Borgess participation despite the fact that the actual county Borgess resides in showed a large excess of operating rooms. Furthermore, in the Jackson Outpatient Surgery Center, BCBSM again used a different standard in calculating EON. Foote Hospital in Jackson closed down four operating rooms, while Jackson Outpatient Surgery Center opened five operating rooms. This is despite the fact that EON calculations did not indicate that another operating room was needed.

BCBSM should address these deficiencies in the new ambulatory surgical facilities provider class plan. To increase the likelihood that the new provider class plan will meet the access goal, BCBSM should take the following recommendations into consideration:

- BCBSM should establish reasonable EON guidelines that will be applied uniformly throughout the state. The new EON guidelines should allow for participation by more physician-owned ASFs in order to give subscribers a choice between hospital outpatient centers and physician-owned ASFs. However, new EON guidelines need not act to allow any and all ASFs to participate. BCBSM is justified in keeping a needs based formula, however, this formula should be applied reasonably and uniformly for all providers.

- BCBSM notified the Insurance Bureau on December 10, 1999 that it is planning to eliminate the multi-specialty requirement. BCBSM stated that no ASF would be prevented from being considered for participation because it fails to meet the multi-specialty requirement. As BCBSM establishes new participation qualifications, it is encouraged to consider developing different EON criteria for single-specialty clinics such as vision clinics and endoscopy clinics so that these unique ASFs do not affect the overall general surgical need in a given service area.

- In computing EON, there should be a minimum number of procedures performed per room (e.g. 1200). The EON criteria should be based only on BCBSM certificate covered services. Only surgeries that cannot be performed in a physician's office should count towards the minimum number of procedures.

- The trading of operating rooms should no longer be included in EON calculation. Hospitals closing ORs in the hospital in order to open ORs at an ASF create an unfair situation, as physician owned ASFs do not have a fair opportunity to compete for participation. The transfer of rooms also acts to increase capacity within service areas because hospitals can eventually reopen those same ORs. Eliminating the transfer of rooms will also help prevent under-utilization of operating rooms within service areas.

- In order to be eligible to participate with BCBSM, an ASF should be able to demonstrate that it is currently performing at least 900 cases a room per year for non-BCBSM subscribers. The logic being that BCBSM currently has approximately 25% of

the market, therefore, providers can expect an increase of 25% in their cases upon becoming a BCBSM participating provider. This formula can also be subject to change upon continual analysis of BCBSM's share of the marketplace.

- BCBSM should develop a formula that accounts for operating rooms used solely for inpatient procedures and trauma cases. Emergency rooms should not be used in calculating BCBSM's EON. Michigan Department of Community Health has indicated that it is very difficult to get accurate figures on the breakdown of inpatient vs. outpatient procedures per operating room. However, enough data is available to make reasonable assumptions on these procedures and develop an EON formula that is based primarily on outpatient surgical procedures.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, BCBSM's achievement of its quality of care objective was examined. Included in this analysis are the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM methods of communication with ambulatory surgery providers. These factors were reviewed to assure that BCBSM not only encourages provider compliance with the expected standards of ambulatory surgical care, but also that it keeps abreast of new technological advances available to treat those BCBSM members that require such services. All of the above factors impact the quality of ambulatory services delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review, are described below.

BCBSM has taken a twofold approach to achieving its quality of care objectives for the ASF provider class. First, BCBSM attempts to promote the quality of health care delivered by providers through the enforcement of provider qualifications and utilization review programs. Second, BCBSM claims that it strives to forge strong relationships with participating providers by designing programs directed toward effective servicing and communication.

To ensure acceptable levels of care provided by providers, BCBSM requires that these providers meet the participation qualifications and performance standards listed on pages 3 and 4 of this report. BCBSM states that provider qualification status is continually monitored to ensure subscriber access to competent providers who are not involved in fraud or illegal activities.

An important quality objective is the appropriate management of quality issues. BCBSM requires ASFs to develop and implement their own utilization management and peer review programs. These programs must:

- Assess the quality of care provided to patients to ensure that qualified individuals provide proper services at the proper time.
- Identify, refer, report and follow up on quality of care issues and problems.
- Monitor all aspects of patient care delivery.

BCBSM also requires ASFs to have a utilization management and peer review plan that identifies purposes, goals, mechanisms and personnel responsible for all parts of the plan, including:

- Quality, content and completeness of the medical records.
- Clinical performance.
- Quality and appropriateness of diagnostic and treatment procedures.
- Evaluation of tissue specimens.
- Medication utilization.
- Patient satisfaction.
- Quality and appropriateness of anesthesia.
- Arrangements for patients requiring hospitalization following ambulatory surgery.

BCBSM states that it ensures that ASFs meet its utilization management and quality assurance requirements by requiring that such facilities are accredited. Accrediting agencies conduct on-site visits and check for proof of appropriate utilization management and quality assurance programs both when the ASF is initially accredited and when it is re-accredited.

BCBSM asserts that it also conducts periodic surveys of ASFs to ensure that the ASFs continue to meet its requirements. These surveys supposedly check to make sure that the ASF has utilization management and quality assurance programs in place. BCBSM did not, however, provide any information that illustrates how many of these surveys were conducted during the two-year period under review.

During the period under review, BCBSM completed a total of 8 ambulatory surgery facility audits. All of these audits took place in 1996. These audits revealed situations in which the benefit requirements were not met by certain ASFs and resulted in a $25,000 recovery. Failure to meet BCBSM's benefit requirements includes: services that are not medically necessary, services that were not prescribed by a physician, incorrect coding by providers and billing for a non-payable diagnosis or for a non-covered modality.

The ASF participation agreement states for medical records and billing reviews: Facility will allow BCBSM to conduct reasonable standard reviews of facility's medical and billing records related to covered services provided to members pursuant to this agreement. The facility will receive 14 days advance written notice from BCBSM advising facility of the review and setting forth the scope of the medical and billing records to be reviewed. The facility will provide BCBSM with on-site access during the facility's regular business office hours to all appropriate medical and billing records of covered services to members as may be necessary for benefit determination, and/or verification of compliance with the requirements of this agreement and related BCBSM policies and procedures. All standard reviews will be initiated and completed, including receipt by facility of a notice of findings within 24 months from the date of payment, excluding cases under appeal. At the request of BCBSM, the facility will provide BCBSM with copies of such requested medical and billing records in conjunction with audits of utilization within a reasonable time from the date of request and in exchange for reasonable payment.

The ASF participation agreement also states that for financial audits: the facility will allow BCBSM to conduct reasonable audits of facility's financial records. Such financial audits shall be initiated and completed within 24 months of the close of the fiscal period subject to the audit. Facility will provide BCBSM with on-site access during facility's regular business hours to all appropriate financial records as may be necessary for establishing appropriate payment liabilities. The findings resulting from any financial audit undertaken pursuant to this section shall be discussed with facility.

BCBSM's present audit process with respect to ASFs does not actually serve to enhance quality of care. BCBSM's review and audit process only focuses on medical records, billing reviews and financial audits. The audits focus on whether the services provided met BCBSM's benefit criteria. The audit process does not address the actual quality of care provided to BCBSM members. BCBSM audits do not focus on quality indicators, such as patient outcomes, the proper treatment options for a patient's condition or patient satisfaction. These types of quality indicators are important as the delivery of surgical procedures increasingly moves into outpatient settings.

BCBSM states that in addition to enforcing provider qualifications, BCBSM maintained open communications with ambulatory surgery facility providers during the period of review. BCBSM achieved this through various means such as through corporate communications and by offering providers a formal appeals process as a means to resolve disputes.

BCBSM states that it communicated and educated ASFs through its provider publications and inquiry departments. Participating ASFs routinely receive BCBSM's publication *Hospital and Facility News*. BCBSM also has regional field services representatives for on-site, individualized provider education. Participating ASFs also received the *Guide for Ambulatory Surgery Facilities*. This comprehensive manual provides detailed instructions

for serving BCBSM members. The manual in effect during the review period was issued by BCBSM in January 1994. The guide includes information pertaining to the delivery of ambulatory surgical care, including benefit programs and criteria, member eligibility, facility participation criteria, reimbursement methods and criteria for covered services, information about BCBSM's provider inquiry department and BCBSM's claims appeals processes. This manual is updated regularly and designed to reduce provider confusion surrounding BCBSM criteria and guidelines. BCBSM made several minor updates to the manual during 1997.

One area in which BCBSM did not appear to communicate well with providers was regarding its EON criteria. BCBSM's EON policy seems ambiguous and has not been adequately communicated to providers. In the *Guide*, BCBSM states "Your facility must meet BCBSM's evidence-of-necessity test, which determines whether there is a need for additional outpatient surgery operating rooms in a service area." BCBSM fails to include, however, any indication of what the criteria is or what a facility needed to do in order to meet the criteria in order to participate with BCBSM.

Furthermore, BCBSM did not explain its criteria to providers whose application for participation was suspended or denied because it did not meet the EON. While BCBSM included the formula used to calculate EON in its letters, the data it used to make the determination was not included. In its letters to providers informing them of their participation status, BCBSM did not include any worksheets or figures that illustrated why providers either met or did not meet the EON criteria. Providers claimed that repeated requests to see the EON criteria were denied by BCBSM.

In addition, the EON and other quality criteria are flawed because BCBSM does not review or re-certify ASFs. Once an ASF is granted participation status, its compliance with the EON is not regularly reviewed. This does not further quality of care for BCBSM subscribers.

BCBSM did not engage in any meetings with statewide ambulatory surgery associations during the review period. The Michigan Ambulatory Surgery Association was formed in November of 1997 and was not active during the period under review. However, the two entities have yet to meet to discuss ambulatory surgical issues.

BCBSM has developed a formal appeal process applicable to ASFs as required by the Act. The appeal process serves to resolve claim or audit disagreements. ASFs are informed of the appeals process through the *Hospital and Facility News*, the provider manual and the ASF participation agreement.

There are many different levels of the appeals process. The provider starts with a routine inquiry to BCBSM and can follow with a written complaint asking for a reconsideration

review. If the provider is not satisfied with the reconsideration, he or she may submit a written request for a Managerial-Level Review Conference. During this conference, BCBSM and the provider discuss the dispute in an informal setting and explore possible resolutions of the dispute.

If the provider is dissatisfied with the managerial-level review, he or she or the provider can request an external peer review. If this review is decided in favor of BCBSM, the provider will pay the costs of the external review. If the review is decided in favor of the provider, BCBSM pays the costs.

For disputes involving administrative and/or billing and coding issues, a provider may request a review by an internal review committee. The internal review committee is composed of three members of BCBSM senior management. If providers are unhappy with the internal review committee decision, they can appeal to the provider relations committee. The provider relations committee is a subcommittee of the BCBSM Board of Directors composed of BCBSM participating professionals, community leaders and BCBSM senior management.

Providers that go through BCBSM's appeals process and remain dissatisfied can appeal to the Insurance Bureau for an informal review and determination. If the provider remains dissatisfied, they can move to a contested case hearing pursuant to Section 550.1404(6) of the Act. Appeals of a decision issued as results of a contested case hearing are subject to appeal in the circuit court. At any time after the written complaint or reconsideration review and management review conference steps, the provider may attempt to resolve the issue through action in the appropriate state court setting.

During the period under review, there were no appeals filed on behalf of ASFs at any level of the dispute resolution process.

Several providers testified that ASFs offer a better quality of care than hospital outpatient surgery centers. This includes lower rates of infection, quality of physician-patient interaction, length of wait before surgery and higher Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditations in safety and quality compliance scores than hospitals.

Providers did not include overall data to support claims of lower infection rates than hospitals. However, one study of Columbia/HCA's ambulatory surgery centers showed that system-wide post-op infection rates are 0.3%, whereas the national average is at 6%[4]. While this article speaks directly of ASFs owned by the Columbia/HCA Healthcare Corporation, it supports a common view that ASFs tend to have lower infection rates than

4 Gail Stout. "How Columbia/HCA's Ambulatory Centers Operate." Journal of Healthcare Resource Management, (April 1996).

hospitals. The main reason is the absence of very ill patients. In hospitals, nurses and other hospital employees walk from room to room and carry bacteria to each room. Healthy people needing outpatient surgery usually frequent ASFs and thus there is a less likely chance of bacterial infection. In addition, patients in ASFs rarely encounter other patients before, during or after their surgery compared to hospitals which often hold numerous patients in the same holding area.

Providers also testified that they scored higher on the JCAHO evaluations than most hospitals. An example of this is Ingham County. When compared, Olin Health Center and Genesis Center received the highest ratings.

While this is only a sample of one county, it demonstrates that there are cases in which ASFs deliver a level of care that is rated higher quality by JCAHO.

Olin Health Center – Michigan State University	Accredited with Commendation 1997
Genesis Center, PLC	Accredited 1998
Michigan Surgical Center	Accredited w/recommendations for improvement 1999
Greater Lansing Ambulatory Surgery Center Company	Accredited w/recommendations for improvement 1997
E.W. Sparrow Hospital	Accredited w/recommendations for improvement 1999
Ingham Regional Medical Center	Accredited w/recommendations for improvement 1998

Chart from www.jcaho.org

JCAHO reviews both hospital outpatient departments and ambulatory surgical facilities using extensive criteria that focus on quality of care. JCAHO analyzes each facility for different areas relating to quality of care. These areas include: patient rights and organization ethics, assessment of patients, care of patients, education of patients and family, continuity of care, improving organization performance, leadership, management of the environment of care, management of human resources, management of information, surveillance prevention and control of infection. JCAHO then issues each facility a score for each category ranking from a 1=Substantial Compliance to a 5=Noncompliance. Based on a compilation of the different scores, JCAHO issues an accreditation ranging from accredited with commendation, accredited, accredited with recommendations for improvement, provisional accreditation, conditional accreditation, preliminary non-accreditation or adverse decision.

ASFs seem to offer ease and accessibility that cannot be matched by hospitals. While there is no specific data, it is obvious by simple comparison that ASFs have an advantage.

Parking problems are minimal in ASFs and walking distance is far less than most hospitals. ASFs are also usually located in less congested areas.

BCBSM continues to participate almost exclusively with hospital owned ASFs. BCBSM states that in the absence of an ASF, members can receive care from a hospital outpatient department or a physician's office. However, it seems that failure to participate with physician-owned ASFs in many cases denies BCBSM members the highest quality of care. While it does appear that many patients receive quality care in an ASF, this in no way implies that hospitals do not also offer a high quality of care.

Another argument presented by providers is that the five major surgical categories limit quality of care by not allowing centers of excellence. Again, providers make the argument that by not participating with centers of excellence, BCBSM is denying its members the best quality of care.

In addition to provider testimony, the Insurance Bureau received in excess of 600 form letters signed by patients of various ASFs. These letters urged the Insurance Bureau to find BCBSM in violation of the statutory goals of the Act because it did not participate with the selected ASF. Patients also testified to the quality care that they had received by going to an ASF and the lower costs compared to hospital care.

BCBSM argues that ASFs providing several categories of surgery can benefit from economies of scale through shared human and capital resources. BCBSM contends that in addition to lowering costs, the five surgical categories increases the quality of care.

One study supplied to the Insurance Bureau showed that high-volume surgery centers result in lower costs and increased quality[5]. The study performed by a Johns Hopkins team of researchers found that physicians in high-volume surgery centers developed an expertise in certain surgeries. Physicians arranged the cases so that each physician dealt with certain cases. The results of the study showed that high-volume surgery clinics reduced the mortality rates, length of stay, and charges per case. These reductions were a result of increased expertise of the physicians due to the high volume. This study indicates that single-specialty, high-volume clinics may have a positive effect on the quality and cost of ambulatory surgery. However, changes need to be made to the EON formula in order to account for single-specialty surgery centers.

Findings and Conclusions - Quality of Care

During calendar years 1996 and 1997, the years under review, BCBSM relied upon its list of qualifications for participating ASFs as a means of assuring that members received

5 Deborah J. Neveleff. "High-Volume GI Surgery Centers Have Lower Costs, Better Outcomes." Gastroenterology Practice Options, (November 15, 1999).

quality ambulatory surgery. BCBSM also relied on audits of ASFs to identify when its benefit parameters were not being met.

Based on all of the information analyzed during this review, it has been determined that BCBSM did not meet the quality of care goal stated in the Act for calendar years 1996 and 1997 and that such failure was within BCBSM's control. This decision is based on the following factors:

- BCBSM does not review or re-certify ASFs. Once an ASF's participation status is granted, its compliance with EON is not regularly reviewed.

- BCBSM's audit process for this provider class does not really measure the quality of the services provided. While BCBSM requires ASFs to develop and implement their own utilization management and peer review programs, its own auditing process is deficient. BCBSM's audit process merely looks at a patient's chart to determine whether the services provided met its benefit requirements or whether the provider complied with all of its documentation requirements. Such audit procedures determine only if a provider followed BCBSM's rules; they are not designed to actually enhance quality of care. None of the audits conducted during the review period focused on quality indicators, such as patient outcomes, proper maintenance of equipment or patient satisfaction. These quality indicators become more important as advances in technology and treatment techniques evolve.

- BCBSM did not communicate quality standards clearly to providers. BCBSM did not provide clear quality standards as a basis for ASF participation. The EON was ambiguous and was not applied uniformly. BCBSM did not disclose any of the data used in making its decisions to providers, it merely denied participation to those not meeting the EON.

In order to ensure that its revised ambulatory surgery facilities provider class plan meets the quality goal, BCBSM should take these recommendations into consideration during its preparation of a modified provider class plan:

- In a letter sent to the Insurance Bureau dated December 10, 1999, BCBSM indicated that it intends to eliminate the multi-specialty requirement so that single specialty ASFs will not be prevented from being considered for participation. BCBSM is encouraged to consider developing different EON criteria for single specialty clinics such as vision clinics and endoscopy clinics so that these unique ASFs do not affect the overall general surgical need in a given service area.

- BCBSM is encouraged to require an ASF to have a minimum number of operating suites in order to demonstrate that there is sufficient support staff, supplies and room in

that ASF. BCBSM should modify its criteria as needed to accommodate ASFs in rural areas.

- Due to demographical changes and the continually changing needs of BCBSM subscribers, BCBSM should re-certify all ASFs to ensure that they comply with all of BCBSM's reasonable standards within one year after the new plan is in place and then re-certify ASFs every three years after that. Re-certification will act to keep overall health care costs low because operating rooms can be opened and closed depending on the needs of the community. Re-certification will prevent ASFs from gaining participation and not performing the required amount of procedures needed to meet the EON. ASFs that fail to meet BCBSM's reasonable criteria during the re-certification process should have its participation status terminated until such time that the facility is able to comply with BCBSM's participation requirements.

- BCBSM should make a good faith effort to solicit input from the associations of all affected provider groups in developing a new ambulatory surgical facilities provider class plan and be able to provide written documentation to support that such input was indeed obtained from all affected provider groups.

- BCBSM should develop and implement new utilization review and quality assessment programs that focus less on monetary recoveries and more on cost and outcome objectives for ambulatory surgery services. This includes setting criteria for the planning and monitoring of care and the periodic re-certification of all ASF facilities.

- BCBSM should improve communication with ambulatory surgery providers through the development of a liaison committee composed of both hospital-owned and physician-owned ASFs. This committee should meet as BCBSM prepares its modified provider class plan to render advice and consultation to BCBSM. After the modified plan is in place, the committee should meet at least semi-annually to discuss issues such as proposed modifications to the participation agreement, reimbursement arrangements for these providers, practice guidelines and protocols, provider manual updates and technological advances. All providers need to be specifically informed as to how individuals are to be appointed to the committee, who is on the committee, how to provide input to the committee and how often and when the committee will convene. In order for this committee to sufficiently serve as a vehicle of enhanced communication between BCBSM and its providers, BCBSM should ensure that the work of this committee has validity.

- BCBSM should clearly communicate in its applications for participation all of the criteria and quality standards that ASF providers must meet in order to be eligible for BCBSM participation. These standards must be reasonable and applied uniformly to all types of ambulatory surgery providers. These standards should be available, upon request, to

all potential and active providers. Letters from BCBSM denying participation should include the specific criteria that the ASF did not meet and what the facility needs to do to be able to be reconsidered for BCBSM participation.

- BCBSM should develop methods for gauging subscribers' preferences. The Insurance Bureau received over 600 subscriber form letters that testified to the quality, low cost, and overall positive experiences they had with non-participating physician owned ASFs. While ASF interests solicited nearly all of these letters, it still demonstrates subscribers' preferences to have certain surgeries performed in an ambulatory surgical facility. BCBSM should take subscribers' interests into account as it develops the modified provider class plan.

Cost Goal:

The cost goal in Section 504(1) of the Act states that "[P]roviders will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

After application of the cost formula found in Section 504 of the Act using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure used to determine BCBSM's achievement of the cost goal will be as follows:

> The rate of change in the total corporation payment per member for the ambulatory surgery facilities provider class for calendar years 1996 and 1997 shall not exceed 3.9%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal, based on the review of data provided by BCBSM and other sources during the review period, are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + REG)]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percent changes in the implicit price deflator for Gross National Product (GNP) over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage changes in per capita GNP in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the November 1998 population data obtained from population reports (Series P-25) published by the Bureau of Census, as provided to the Insurance Bureau by the United States Department of Management and Budget, and economic statistics for the GNP and implicit GNP price deflator published in the December 1998 edition of "Economic Indicators" by the U. S. Department of Commerce, the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

% change in implicit GNP price deflator	
1996	1.9
1995	1.9
2 yr. average	1.9

REG = Real Economic Growth as defined in the cost goal formula:

% change in per capita GNP in constant dollars	
1994	1.3
1995	2.3
1996	1.7
1997	2.7
4 yr. average	2.0

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 3.9%, as shown below:

Inflation = 1.9

Real Economic Growth = 2.0

$$\frac{[(100 + 1.9) \times (100 + 2.0)]}{100} - 100 = 3.94\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to the Insurance Bureau, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4) of the Act.

As stated in Section 504(2)(e) of the Act, the "'[R]ate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination." The cost and membership data for the ambulatory surgery facilities provider class plan for the calendar years 1996 and 1997, as filed with the Insurance Bureau by BCBSM, are presented below. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

The figures shown below illustrate that BCBSM has met the cost goal for the determination period. The two-year arithmetic average increase for the ASF provider class plan equals 3.4%. This falls below the 3.9% cost goal calculation pursuant to Section 504 of the Act.

1995-1997 Ambulatory Surgery Facilities
Total Utilization and Payment Experience

BCBSM Ambulatory Surgical Facility Figures	1995	1996	1997	Average Yearly Rate of Change
Total Members	2,141,899	2,534,576	2,800,270	14.408
Total Visits	9,383	9,117	12,230	15.655
Total Payments	$10,369,526	$10,784,956	$14,178,159	17.734
Cost Performance				
Visits/1000 Members	4.38	3.60	4.37	1.764
Payments/1000 Members	$4,841.28	$4,255.13	$5,063.14	3.441
Payment/Visit	$1,105.14	$1,182.95	$1,159.29	2.520
Cost/Member/Year	$4.84	$4.26	$5.06	3.441

A number of factors affect BCBSM's cost goal performance. Some of these factors are discussed below:

The two-year average increase in payments per 1000 members was 3.44%. There was also a 1.8% increase in visits per 1000 members. These moderate increases helped BCBSM to meet the cost goal.

Musculoskeletal disorders and diseases of the eye combined represented almost 50% of the total payments and 40% of the total visits made to ASFs. Grouped together with podiatry disorders, disease of the ear, nose and throat, and female reproductive system care, these procedures make up the top 50 diagnostic codes.

Exhibit A shows the increases and decreases in payment per member by type of service in facilities.

BCBSM reimburses ASFs on a price-based methodology. BCBSM's reimbursement policies are as follows:

For most ambulatory services, BCBSM uses a price-based payment system based on the lower of the facility's charge or BCBSM's procedure-specific price for a covered service. In a situation where there is insufficient data to develop a price-based payment for a procedure, a cost-based system is used.

The price based payment method is driven by two components:

- Payment unit = HCPCS code
- Payment level = Pricing formula

The payment unit refers to surgery-related activities while the payment level for each HCPCS code is determined by the pricing formula.

BCBSM also uses two other reimbursement methods in rare cases. The nominal price-based payment is for surgical procedures that are predominantly performed in a physician's office. When these procedures are performed in an ambulatory setting, the ASF receives a nominal price-based payment that is limited to a minimum dollar amount per surgical procedure. These types of procedures are reimbursed based on the physician's practice expense relative value unit, and then goes through the price based payment formula mentioned above.

The statewide percentage-of-charges payment is based upon an initial ratio of charges to total charges applied to cost. This method is only used for two categories of services: cancellations that occur on the day of surgery and selected outpatient surgical services with statewide utilization of under 25 cases. In these cases, reimbursement is based on a statewide percentage factor of providers' charges.

Outpatient surgical procedures are reimbursed on a claim-by-claim basis. ASFs are not subject to BCBSM interim payments nor year-end cost settlements.

Although BCBSM met the statutory cost goal, steps should be taken to ensure that it continues to meet future cost goals and also strive to keep overall health care costs down.

Some providers testified of unfair reimbursement practices. Some of the cases mentioned involved hospital outpatient departments being reimbursed by BCBSM for facility fees. BCBSM does reimburse hospital outpatient departments at a 23% higher rate on average

due to certain factors. These factors include such things as 365-day, 24-hour care, food services, graduate medical education, expensive diagnostic equipment, 24-hour nursing care, overnight facilities, etc. There is little doubt that ASFs provide care at a less expensive rate. There is no difference in the reimbursement of freestanding-hospital-owned ASFs and physician-owned ASFs.

BCBSM and the MHA argue that widespread participation with physician owned ASFs would result in an oversupply of hospital operating rooms. This would result in higher costs to hospitals and to BCBSM through the Participating Hospital Agreement. BCBSM states that it has a "vested interest in ensuring that hospitals remain solvent so they can continue to serve the community," which is why BCBSM pays hospital outpatient departments slightly more.

Some providers testified that although BCBSM met the statutory cost goal, BCBSM's cost goal performance does not reflect the amount of money that could be saved by participating with more physician-owned ASFs. Providers testified that overall health care costs would go down if physician-owned ASFs were allowed to compete at the same level as hospital-owned ASFs. One reason is that the costs associated with ASFs are less than hospital outpatient surgeries. Another reason providers give is that competition for customers will also help keep costs down thus forcing hospitals to become more efficient. Providers state that there is a great need to reduce overall health care costs as BCBSM has increased its premiums at a statewide average of 25% for the first quarter of 2000.

While issues regarding participation with physician owned ASFs has been discussed previously in the access and quality goals, the economics of participation warrants further discussion here. It appears that the current CON process does limit increases in overall health care costs. The main concern in allowing full participation for physician owned ASFs, and even the proliferation of hospital owned ASFs is overall health care costs. In this case, too much movement of the hospital base to outpatient facilities may be counterproductive to overall health care costs[6]. Hospital facility pricing calculates a certain percentage for overhead and other facility costs mentioned earlier. Hospitals will simply seek to recover lost overhead through other services that are less elastic such as emergency care and other inpatient services in which the patient or insurer has little choice.

A study, done by Harry C. Wong, M.D. supports these assumptions[7]. Wong's study of increased ambulatory surgical interests found that medical costs to the community are increased when the addition of operating rooms leads to a decreased utilization of existing operating rooms. Therefore, if the number of operating rooms increases without a similar

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6 Uwe E. Reinhardt. "Spending more through 'cost control:' Our Obsessive Quest To Gut The Hospital," Health Affairs, Volume 15, Number 2 (1996).
7 Harry C. Wong, M.D. "The Evolution Of Free-Standing Ambulatory Surgical Care." Journal of Ambulatory Care Management, Vol. 1. (February 13 1990), p.11-20.

increase in share of the market of ambulatory surgery, it results in an under-utilization of existing operating rooms.

However, BCBSM's EON criteria did not act in a way to decrease the cost for BCBSM members. The purpose of the EON is to keep health care costs low by preventing over-capacity and under-utilization. The EON failed to do that because BCBSM did not re-certify ASFs or impose EON criteria on hospital ORs. A spreadsheet provided to the Bureau by BCBSM illustrated the excess surgical capacity in certain counties.

County	Data Source*	Procedures	Demand Need**	Existing Rooms	Over Capacity ORs
Jackson	1996	22,137	18	19	1
Kalamazoo	1996	35,461	30	39	9
Ingham	1996	53,478	45	52	7
Oakland	1995	128,563	107	130	23
Iron	1995	384	1	3	2
Kent	1996	72,001	60	77	17
Monroe	1994	9,006	8	8	0
Marquette	1994	9,683	8	13	5
Genesee	1994	46,561	39	52	13

* Data Source: Michigan Department of Community Health, Annual Hospital Statistical Questionnaire.
** Based on 1,200 procedures per operating room.

It is apparent that the EON does not prevent over capacity. BCBSM's method of applying the EON does not control health care costs for BCBSM members.

BCBSM does recognize the cost savings available through the use of ASFs. BCBSM itself has stated in its provider class plan annual report that:

"The lower costs associated with outpatient surgery allows ambulatory surgical facilities to offer a cost effective setting with high quality standards for performing many outpatient surgeries."

"Ambulatory surgery facilities are noteworthy for generally having low overhead costs with the technical ability to offer cost-effective, high quality services for many procedures."
"By participating with BCBSM, qualified ambulatory surgery facilities increase accessibility for our members and offer them quality services that are timely, convenient and cost-effective. This allows for increased availability of hospital surgeries that are more appropriate at the hospital location."

Thus in order to facilitate more ambulatory care alternatives, an equitable solution must take place that provides for more ambulatory care while keeping underutilized rooms and their consequent costs to a minimum.

Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM met the cost goal stated in the Act for the ambulatory surgery facilities provider class.

BCBSM should continue to search for ways to keep overall health care costs down. By BCBSM's own admission, ASFs offer a low-cost, high-quality alternative to hospital outpatient departments. BCBSM needs to seek a balance that will promote low cost, high quality care, while preserving the hospital institution and guarding against under-utilized operating rooms.

The EON quality criteria employed by BCBSM has failed to keep operating rooms from being under-utilized. Counties such as Oakland and Kent had over capacities of operating rooms of 23 and 17, respectively. BCBSM's administration of its EON has not acted in a way that prevents over capacity and should be revised accordingly.

In BCBSM's December 10, 1999 response to comments on the ASF provider class plan, it indicated that it expects the differential in reimbursement between ASFs and hospital outpatient departments to be reduced. The Participating Hospital Agreement Advisory Committee has recommended that hospitals be paid at the same rate as ASFs. While hospital outpatient departments will still be compensated for graduate medical education, bad debt and capital overhead, the overhead formula will be reconfigured so that it is calculated per surgery rather than per hospital so the cost of unused operating rooms will not be covered.

Determination Summary

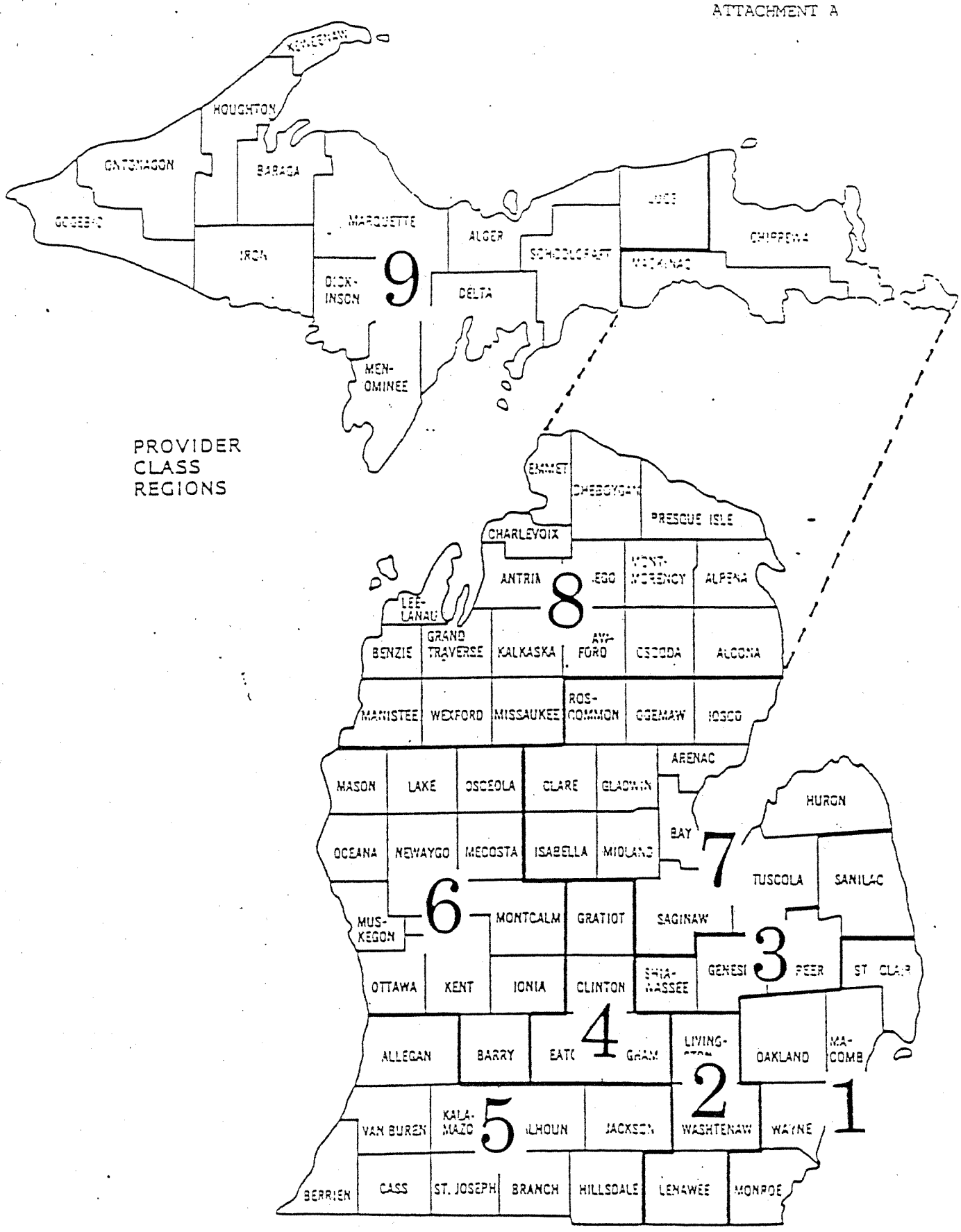
In summary, BCBSM substantially achieved only the cost goal during the two-year period under review for the ambulatory surgical facilities provider class. The ambulatory surgical facilities plan did not substantially meet the access and quality goals as provided in Section 504 of the Act. Inasmuch as BCBSM was not able to provide documentation to demonstrate that its failure to meet either of these goals was reasonable, this determination report is being issued pursuant to Section 510(1)(c) of the Act. Therefore, pursuant to Section 511(1) of the Act, it will be necessary for BCBSM to transmit a provider class plan that substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated herein within six months of the date of this determination report.

Section 511(1) of the Act states "...[I]n developing a provider class plan under this subsection, the corporation shall obtain advice and consultation from providers in the provider class and subscribers, using procedures established pursuant to section 505."

A new provider class plan should properly address the deficiencies and recommendations presented in the previous discussions of goal performance.

The Insurance Bureau reserves the right and is willing to clarify these suggestions to providers and BCBSM. In addition, the Commissioner is willing to facilitate further discussions and negotiations between BCBSM and providers that will ultimately lead to a revised provider class plan that will result in greater access, better quality and lower costs for ambulatory surgical services.

ATTACHMENT A



State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

Attachment

Insurance Bureau
Frank M. Fitzgerald, Commissioner

P.O. Box 30220
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MEMORANDUM

DATE: February 23, 2000

TO: File

FROM: Brian Reed

SUBJECT: Summary of Ambulatory Surgical Facilities Provider Class Plan Testimony

On August 23, 1999 at approximately 9:30 am, the public hearing was called to order. Representing the Insurance Bureau were Susan M. Scarane, Director of Provider Class Plans and Brian Reed, graduate assistant to Susan Scarane. Approximately 35 people were in attendance on behalf of varied interests. Ms. Scarane provided a brief introduction as well as a review of the issues covered in the Notice of Hearing. All participants were invited to submit additional testimony regarding ambulatory surgical facilities and hospital provider class plans by October 31, 1999. Following the introduction, oral testimony regarding input on BCBSM's ambulatory surgical facilities was welcomed. At the start of the meeting, testimony cards were handed out. Oral testimony followed the order in which testimony cards were received. Provided in this memorandum is a brief summary of both the testimony presented at the public hearing and written testimony received throughout the review period. There was no oral testimony regarding the hospital provider class plan at the public hearing.

Summary of Arguments:

The first speaker was Floyd Goodman, M.D. Goodman stated that BCBSM's ASF provider class plan violated three statutory requirements of Public Act 350.

Goodman claims the ASF provider class plan did not meet the access goal set forth in the act because it participated with less than 50% of eligible ambulatory surgical facilities. Goodman states that BCBSM only participates with hospital owned ASFs, and only participates with freestanding ASFs when it is court ordered. Goodman states that BCBSM's Evidence of Need (EON) has denied ASFs even when they are granted certificates of need. Goodman also states that BCBSM's actions have lead to fewer procedures being done in ASFs. Only 30,000 procedures were done in ASFs from 1995-1997 while 600,000 were done in hospitals. Goodman feels that at least 70% of procedures can be done in an ASF.

Goodman also stated that ASFs offer a higher quality of care which BCBSM denies its members by using its EON criteria.

Goodman states that although BCBSM met the cost goal technically stated in the Act, the cost goal only encompasses reimbursement and does not take into account money that could be saved. Goodman states that participating with ASFs could save much more money.

The second speaker was Traci Messenger who represented her husband Greg Messenger, M.D. Messenger stated that he also believes that BCBSM is in violation of the three statutory goals. Messenger contends that BCBSM participates with less than 50% of ASFs and the 22 ASFs that BCBSM does participate with are all hospital owned. Messenger states this is contrary to BCBSM's policies in other states.

Messenger also states that the Greater Lansing Ambulatory Surgery Center (GLASCCO) received its certificate of need (CON) from the Michigan Department of Health based on 1000 surgical cases per operating room. However, BCBSM refused to participate with GLASCCO citing their EON criteria of 1,200 cases per operating room. Messenger states that BCBSM's claims that their EON is based on the same criteria as the CON. Messenger contends that GLASCCO was told BCBSM would not participate with them unless it was owned by a hospital. BCBSM continues to withhold the criteria used to deny GLASCCO. The Wayne County Circuit Court ordered a preliminary injunction that BCBSM could not exclude GLASCCO from participation.

Messenger contends that in Lansing, patients frequently have to wait 3 to 6 weeks for elective outpatient surgery in the local hospitals. Messenger further contends that BCBSM's position that "3 to 6 weeks does not appear to be excessively long" is not acceptable.

Messenger went on to illustrate how BCBSM fails to satisfy the cost goal. He stated that BCBSM increases their premiums at 300 to 500% the national rate of increase. Despite health care costs skyrocketing in Michigan, BCBSM continues to pay hospital owned ASFs 23% more than freestanding ASFs for the same procedures. By participating with freestanding ASFs, Messenger feels that these costs will come back into reason.

Messenger also states that ASFs offer a greater quality of care. Messenger points out that there are statistically less nosocomial infections in freestanding ASFs than in hospitals.

The third speaker was Julie L. Lester, Director of Medical Economics and Health Care Delivery for the Michigan State Medical Society. Lester expressed concern over the fact that BCBSM has declined to participate with freestanding ASFs citing their EON process. Despite the fact that these ASFs have met the state of Michigan's CON, they do not meet BCBSM's EON requirements which remain unknown. These freestanding ASFs have not been able to get information on why they are denied from BCBSM.

In addition, Lester argues that BCBSM says that freestanding ASFs will increase health care costs by creating excess capacity. However, Lester contends that freestanding ASFs are reimbursed at a lower rate than hospital outpatient departments. By providing the same services at a lower price, Lester contends that money would be saved thereby decreasing costs to the consumer. Lester states that BCBSM's policies are contradictory to cost

containment concerns. Lester also asks whether hospitals and hospital owned ASFs are being held to the same criteria as physician sponsored ASFs.

The fourth speaker was Robert Wolford, CEO of Surgical Care Center of Michigan. Wolford stated that he represents four licensed ASFs. He is interested in working with BCBSM but feels that BCBSM is being unreasonable.

Wolford stated that BCBSM's EON is unsatisfactory. Wolford contends that BCBSM has no intention of approving freestanding ASFs. In addition, Wolford asserts that BCBSM will not give him any information on why freestanding ASFs are denied participation.

Wolford claims that BCBSM has engaged in discrimination against ASFs and acted to protect hospitals. Wolford gives the example of Spectrum Health-Ferguson Center. Ferguson added 4 operating rooms in 1996 even though other rooms are underutilized. This further diluted the cases per operating room in this service area making it impossible for freestanding ASFs to meet BCBSM's EON of 1,200 cases per room.

The fifth speaker was Linda Kirk of Grand Valley Surgical Center. Kirk echoed the concerns of Robert Wolford that BCBSM was discriminating against non-hospital owned ASFs. Kirk contends that hospital owned ASFs do not have to meet the same EON criteria that freestanding ASFs have to meet. Consequently, hospital owned ASFs continue to add rooms further diluting the cases per room, making it harder for non-hospital ASFs to meet BCBSM's EON criteria.

The sixth speaker was Charles D. Dobis of the Michigan Surgical Center. Dobis claims that ASFs play a bigger role in other states. Dobis also states that most other carriers cover ASFs, but BCBSM continues not to do so.

Dobis also says BCBSM's concerns regarding excess utilization if they were to participate with freestanding ASFs is unfounded. Dobis contends that there is no correlation between utilization and capacity. Dobis says many times, there is a decrease as is the case if cataract surgery rates are compared between hospitals and ASFs.

Speaker seven was Robert Barber of Brookside Surgery Center. Barber stated that BCBSM in essence has established a monopoly for hospitals with their EON criteria. In effect, subscribers are denied access to lower costing ASFs and consequently access to new and useful technology.

The eighth speaker was Michael Richmond of the Surgery Center of Michigan. Richmond echoed the concerns of the previous speakers and gave some examples. One example was how BCBSM told him flat out that they would not give out BCBSM numbers to non-BCBSM ASFs. All ASFs are rejected immediately by BCBSM, however, BCBSM refuses to release data or reasoning for these denials.

Linda Fausey representing Blakewoods and SCM Surgery Center spoke ninth.

Ms. Fausey expressed concerns over the EON process. She felt the EON is unfair and used by BCBSM to monopolize the market. She felt the EON negates the ASFs license to operate

and their CON. Ms. Fausey feels the Act does not allow BCBSM to establish their EON. She feels this is the responsibility of the MDCH.

Ms. Fausey also questioned the constitutionality of the Act in general and many of the definitions within the Act. She stated that Part 5 has never been reviewed for constitutionality. She does not feel that the Act allows BCBSM to establish "licensure standards."

Ms. Fausey also claimed that BCBSM uses the EON to monopolize the market. She stated it is 50% cheaper to get care at an ASF as opposed to a hospital. She feels that BCBSM should not be deciding capacity for ASFs because ASFs are not in a position to cost-load. She further states that there is no evidence of over-utilization since BCBSM has never participated with ASFs.

The tenth speaker was Louise Kirk from Wachler and Associates. Kirk first read a statement by Dr. Francis P. Welsh of the Upper Peninsula, and then she spoke for the Genesis Surgery Center and Superior Endoscopy Center.

Ms. Kirk testified that BCBSM did not meet the access goal of the Act because they participate with less than 50% of ASFs. In addition, BCBSM does not participate with any ASFs in the Upper Peninsula and it only participates with one physician owned ASF in the state.

Ms. Kirk further testified that BCBSM uses the EON to discriminate against physician owned ASFs. Ms. Kirk also states that BCBSM does not communicate how ASFs can meet the EON. In addition, BCBSM does not explain to the denied ASFs why they did not meet the EON. BCBSM refuses to explain or describe its service area or rate of surgery/population. Ms. Kirk states that BCBSM violates section 502(8) of the Act because the denied ASFs are licensed and meet reasonable standards, yet BCBSM still refuses to participate.

Ms. Kirk also feels that the multi-specialty requirement is illogical. Medicare and other payors pay ASFs with only one specialty. Kirk also states that EON and the multi-specialty requirement do not have anything to do with quality. Ms. Kirk states that BCBSM could save money by participating with centers of excellence and also eliminating the EON criteria.

Kirk concluded by saying that cost containment is very important in health care today. ASFs save costs, so why doesn't BCBSM participate with more ASFs.

The 11th speaker was Fernando Bermudez, M.D. of the Eastside Endoscopy Center. Bermudez claims that BCBSM violates the goals for quality of care in a couple ways. First, by requiring that ASFs be specialized in 5 different areas, it excludes those ASFs that specialize in one type of procedure. Second, BCBSM ignores many of the technological advances that have allowed changes in the delivery of ambulatory services. Bermudez claims that BCBSM has ignored the fact that ambulatory surgical procedures can be performed in ASFs at a higher efficiency while also improving on the quality of care.

Bermudez also claims that BCBSM violates the access clause of the Act by refusing to participate with freestanding ASFs, resulting in a lack of access for BCBSM subscribers. In addition, Bermudez contends that BCBSM is perpetuating higher costs for health care. By refusing to participate with freestanding ASFs, BCBSM is simply not letting free enterprise

take its course and letting ASFs compete. BCBSM is content paying the higher costs that hospitals require.

In addition to the testimony presented at the public hearing, a great deal of written testimony was also provided to the Bureau.

There was in excess of 500 form letters submitted to the Bureau from patients that had elected to have surgeries performed at ASFs. These letters attested to the low cost and quality of physician owned ASFs and requested the Bureau find BCBSM in violation of the Act and force BCBSM to participate with these ASFs.

Employees of the Superior Endoscopy Center in Marquette, Michigan also submitted a series of other form letters. These letters posed a series of questions that the employees felt should be asked towards BCBSM.

The following individuals also submitted written testimony that basically addressed the same issues as the various testimonies described herein:

Phyllis J Rutledge, RN
Lowell R. Fisher, D.O.
Edward J. Nebel, M.D.
Mark D. Russell, D.O.
Richard Goodney
John G. Bizon, MD, F.A.C.S.
Representative Mark H. Schauer
Dan L. Hunt, D.O., F.A.C.O.S.
Mark W. Jones, D.O., F.A.C.O.S.
Suzanne M. Hanses, D.O.
Melissa S. Richardson, D.O.
Thomas D. LeGalley, M.D.
Edward J. Brophy, D.O.
Ronald L. Clark, M.D.
Norman J. Licht, M.D.
Joseph M. McGraw, M.D.
G. Barry Wickstrom, M.D.
W. John Bruder, M.D.
Michael J. Forness, D.O.
David S. Lint, M.D.
Vincent R. Prusick, M.D.
John M. Nassif, M.D.
Larry M. Vander Plas, M.D.
Lou Ann Balding
Laura Farnsworth
Gerald R. Peterson
James R. Kesler
Kathy Bryant
William F. Weatherhead, D.O., F.A.C.O.I
Federated Ambulatory Surgery Assoc.
Kristine A. Gorsalitz, R.N., D.O.N.
Thomas F. Huffman, M.D.
Francis P. Welsh, M.D.
John G. Kublin, M.D.
Dennis A. Herzog, M.D.
Richard E. Vermeulen, M.D.
Douglas R. Shearer, M.D.
Jeffrey P. Shaffer
Clemon Pardales, D.O.
Brian E. Helmer, M.D.
Gary L. Walker
Hugh M. Miller
Jeff Colquhoun, M.D.
Larry L. Pack
Pam Dietrich
David A. Detrisac, M.D.
Senator John J.H. Schwarz, M.D.
Bill Hetrick
Donald R. Bohay, M.D.
James L. Keller, M.D.
Krishna K. Sawhney, M.D.
Gregory Uitvlugt, M.D.
Kenneth E. Stephens, Ph.D., D.O.
Laith A. Farjo, M.D.
Larry A. Wickless, D.O.
Cynthia A. Nyquist RN, BSN
Judy Creech, RN
John F. Walling, Jr., D.O.

Gail Albright
Brian Goupil, LPN
Angela R. Farnsworth
Cynthia D. Konken
Peter Keast
Jane Beshore
Marilyn H. Bell

In addition, The Michigan Health and Hospital Association (MHA) submitted written testimony supporting BCBSM performance in the goals stated in the Act. The MHA testified that the EON criteria merely prevents an oversupply of operating rooms in a given service area which in turn keeps overall health care costs down. The MHA supports the EON because the cost of procedures remaining at hospitals would increase if a large portion of outpatient procedures were transferred to other facilities. The MHA feels that BCBSM has met the access, quality and cost goals stipulated in the Act. The MHA states that the EON requirement is a fair assessment of the need for operating rooms. The MHA is especially concerned about the impact that more liberalized EON criteria would have on hospitals. Hospitals must maintain certain overhead such as 24-hour services and access to all patients regardless of ability to pay and losing some outpatient procedures would place a burden on the hospital system. The MHA further claims that hospitals participate with BCBSM and grant substantial discounts from listed charges in anticipation of supplying a certain volume of services to patients. Any "carve-outs" of services that are taken away from the hospitals threaten the future of BCBSM's participating hospital agreement.

BCBSM also submitted testimony. BCBSM defended its performance on the goals stating that they have met the access, quality and cost goals. BCBSM contends that the EON requirement is a reasonable requirement and does not act in a licensing capacity or to duplicate the State's CON process. BCBSM also argues that Michigan is not an "Any Willing Provider" state. Therefore, BCBSM is not obligated to participate with every ASF that has a license. BCBSM also states in its testimony that is is only obligated to cover facility services at participating ASFs and non-participating facility charges are not covered.

BCBSM further claims they do not discriminate against ASFs on the basis of ownership. BCBSM points out that they participate with three physician owned ASFs: Greater Lansing Ambulatory Surgery Center, Toledo Clinic and HealthCare Midwest Surgery Center.

BCBSM also denies that its policies increase costs for BCBSM members. BCBSM states that on average, outpatient hospital departments are reimbursed about 23% higher than freestanding ASFs because of the greater overhead costs associated with hospitals. Overhead includes the different expenses unique to hospitals such as graduate medical education, uncompensated care, bad debt, capital expenditures, and other expenses associated with operating 7 days a week, 24 hours a day. BCBSM contends that along with its members, it has a vested interest in ensuring that hospitals remain solvent so it can continue to serve the community. BCBSM further states that rate increases were mainly the result of increases in prescription drugs, office visits and health care trends. BCBSM claims the fact that it achieved the cost goal for 1996-1997 is evidence that its policies on ASFs contained costs rather than increase them.

BCBSM also stated in testimony that the access goal has been met. BCBSM argues that access is measured not by type of provider, but by services. BCBSM states that the Commissioner in past provider class determination reports such as rehabilitation therapy and hearing specialists has ruled that access meant access to services. BCBSM contends that BCBSM members have adequate access to ambulatory surgery services.

BCBSM further testified that its methodology is neither unfair nor arbitrary and is necessary to contain costs. BCBSM states that the EON controls the supply of facility services that duplicates hospital services. It also acts to limit the number of participating ASFs so that unnecessary utilization from too many facilities in one service area is avoided. BCBSM claims they apply the EON objectively to both hospital and non-hospital ASFs. BCBSM also claims that considering both inpatient and outpatient rooms in its methodology does not undermine its accuracy since operating rooms are not designated as inpatient or outpatient and can be used for both types of surgery.

BCBSM states that allowing facilities to trade existing operating rooms for new operating rooms is not unfair. BCBSM states that in general, tradeoffs of rooms have usually decreased capacity instead of increasing it. BCBSM further states that grandfathering existing ASFs for participation in the early 1992 was not unfair. BCBSM contends that hospital owned ASFs were previously paid for under the Participating Hospital Agreement. These ASFs were transferred to the ASF provider plan in order to lower the level of reimbursement, which in turn lowered costs.

BCBSM concludes by stating that no Michigan court has found the EON to be unlawful and the EON is not discriminatory or impossible to meet. BCBSM requested that the Commissioner pass them on all the goals.

BCBSM Evidence of Need Requirement for Ambulatory Surgical Facilities

EON reviews are calculated for a service area (generally a county), using statistical information from the State of Michigan. The steps used to perform each review are as follows:

Step 1: The number of operating rooms, both inpatient and outpatient, available in the applicable service area is calculated.

Step 2: The number of available operating rooms is multiplied by 1200 to determine overall surgical capacity in the service area.

Step 3: The number of surgical procedures, both inpatient and outpatient, actually performed in the applicable service area is calculated.

Step 4: The overall capacity calculated in Step 2 is compared to the number of surgical procedures calculated in Step 3.

- If the overall capacity exceeds the number of surgical procedures performed, then additional outpatient surgical capacity to serve BCBSM members is determined unnecessary and the EON requirement has not been met.

- If the number of surgical procedures performed exceeds the overall capacity, then there is an indicated need for additional capacity to serve BCBSM members, and the EON requirement has been met.

In addition to the steps listed above, EON can also be achieved if the addition of a participating ASF does not result in an addition to OR capacity in the service area. A typical example of EON of this type is when a provider agrees to close a number of OR's at one facility in the same service area, which is greater than, or equal to the number of OR's it is opening at the ASF.

The EON requirement is just one of a number of participation requirements that a facility must meet to be eligible for reimbursement by BCBSM. To be considered for participation, all facilities must submit a completed application, and meet all requirements.

BCBSM Evidence of Need Requirement For Ambulatory Surgical Facilities (Used until January 1998)

Step 1: Determine Current Demand.

$N = P * R$

Where:

N = Need for outpatient operating rooms in service area
P = Population of service area
R = Rate of surgery per population (hospital and ASFs)

Step 2 Determine Current Capacity.

$C = O * S$

Where:

C = Current Capacity
O = Number of Operating room suites in service area
S = Surgeries per operating room suite per year

Step 3: Determine if additional operating rooms are needed.

$X = N - C$

Where:

X = Additional operating rooms needed
N = Need
C = Capacity

If capacity is greater than need, additional outpatient surgical capacity is unnecessary.

BCBSM EON Calculations

Facility	County	Data Source	Procedures	Demand (Need)	Existing Rooms	Over/(Under) Capacity
Blakewoods	Jackson	1996	22,137	18	19	1
Michigan Surgery Center	Ingham	1996	53,478	45	52	7
Genesis Surgery Center	Ingham	1996	53,478	45	52	7
Oakland Surgi Center	Oakland	1995	128,563	107	130	23
Garrett Eye Center	Iron	1995	384	1	3	2
Grand Valley Surgical Center	Kent	1996	72,001	60	77	17
Mercy Memorial	Monroe	1994	9,006	8	8	0
Upper Peninsula Surgery Center	Marquette	1994	9,683	8	13	5
Genesys Health System	Genesee	1994	46,561	39	52	13

Data Source: Michigan Department of Community Health, Annual Hospital Statistical Questionnaire

Attachment E

EON DETERMINATION FOR BORGESS MEDICAL CENTER IN PORTAGE, MI
February 16, 1996

The EON calculation for the Borgess Medical Center located in Portage, MI is based on need in the three counties neighboring Kalamazoo county. The service area for this facility can reasonably be expected to serve patients these three counties: Cass, St. Joseph, and Van Buren. Kalamazoo county itself does not currently demonstrate need. All calculations are based the 1994 ASF EON calculations, which utilize 1993 data.

County	(1) # of facilities in cty.	(2) # of O/R's in each county	(3) Less one O/R for each facility that treats E/R & trauma & trauma patients	(4) Net O/Rs (2) - (3)	(5) 1,000 cases/ O/R	(6) Total Capacity (4) * (5)
Cass	1	3	1	2	1,000	2,000
St. Joseph	2	5	2	3	1,000	3,000
Van Buren	2	4	2	2	1,000	2,000
TOTAL		12	5	7		7,000

County	(1) Actual Volume	(2) Total Capacity	(3) Actual Volume less Total Capacity (1) - (2)
Cass	1,612	2,000	-388
St. Joseph	2,844	3,000	-156
Van Buren	2,590	2,000	590
TOTAL	7,046	7,000	46

1995 ASF EON CALCULATION
(based on 1994 data)

County	CURRENT USE: Current Use (Procedures)	Current Use (Patients)	Total Use	CURRENT CAPACITY: (1) # O/R Rooms	(2) Surg./ Room/ Year	(3) Current Capacity (1) * (2)	Current Use minus Capacity
Kalamazoo	28,109	1009	29,118	41	1,000	41,000	-11,882

(a) 1/1/95 Population	(b) Surg. rate per population	(c) Est. Need (a * b)	(d) Current Capacity	(e) Est. Need minus Capacity (c) - (d)
229,300	0.10	22,930	41,000	-18,070

Sources

CURRENT USE:

(1) Consists of I/P and O/P procedures for hospitals and # of procedures for the remaining ASFs.

# of I/P & O/P Procedures for hospitals = (Source: 1995 Annual Hospital Survey - Table 5 MI Dept. of Public Health)	21,945
# of O/P procedures for ASFs = (Source: Phone call to facility)	7,173
TOTAL	29,118

CURRENT CAPACITY:

(1) 1994 Annual Hospital Survey: Table 5 - Surgical Room Services (MI Dept. of Public Health). # of surgical suites for ASFs was determined by calling each ASF.

(2) Taken from earlier versions of ASF EON calculation papers.

OTHER:

(a) 1/1/95 Population - Sales & Marketing Management -1995 Survey of Buying Power. BCBSM Corporate Library (F. Palmer).

(b) American Hospital Assoc.: St. of MI - Table 5C (94/95). Ph. # (312) 422-3000.

1998 CON Data

Ambulatory Surgical Center	Ownership	Number of O/R	Number of Surgical Cases	CON/EON Criteria (Divided by 1200)	Meet CON? Currently
Blakewoods	Physician	2	2601	2.1675	Yes
Lansing Surgery Center, Llc (formerly GLASSCO)	Physician	3*	2646	2.2050	No
Jackson Outpatient Surgery Center	Hospital	5*	6396	5.3300	Yes
St. John Surgery Center	Hospital	4	4367	3.6392	No
Harper-Hutzel Hlth Ctr Warren	Hospital	2	1189	0.9908	No
Mercy Mem Comm Hlth Ctr	Hospital	3*	1701	1.4175	No
Sinai Surgery Center	Hospital	4	4777	3.9808	No
Community Surgical Center	Hospital	2*	992	0.8267	No
Providence Medical Center ASC	Hospital	3	3643	3.0358	Yes
Grace Hospital ASC	Hospital	4*	3772	3.1433	No
Providence Surgical Center	Hospital	3	2161	1.8008	No
Waterford Ambulatory Health Services	Hospital	2	1700	1.4167	No
Oakwood Healthcare Ctr - Dearborn	Hospital	2	2306	1.9217	No
University of Michigan Surgery Center	Hospital	4	1547	1.2892	No
Battle Creek Health System	Hospital	4	1762	1.4683	No
Health Care Midwest Surgery Center	Physician	1	1323	1.1025	Yes
Borgess Surgery/Woodbridge Hills	Hospital	4*	1492	1.2433	No
Butterworth Hlth Pavilion-South	Hospital	2	2702	2.2517	Yes
Spectrum Health Surgical Center	Hospital	6	6890	5.7417	No
Genesys Amb Surgerical Cter at Hlth Pk	Hospital	4*	3757	3.1308	No
Saginaw General North	Hospital	5	3752	3.1267	No
St. Mary's Amb Care Ctr	Hospital	5*	4043	3.3692	No
Garrett Eye Ctr	Physician	2	535	0.4458	No
Genesis Center, P.l.c.	Physician	5*	1264	1.0533	No
Oakland Surgi Center	Physician	2	950	0.7917	No
Upper Penninsula Surgery Center	Physician	4	925	0.7708	No
Brookside Surgery Center	Physician	3	1787	1.4892	No
Grand Valley Surgery Center Llc	Physician	4	1790	1.4917	No
Michigan Surgical Center	Physician	4	1307	1.0892	No
Surgery Center of Michigan	Physician	2	1500	1.2500	No

* - Includes Endoscopy Rooms and Endoscopy Surgical Cases

Preliminary Data taken from the 1998 Annual Freestanding Surgical Facility Questionnaire - Michigan Department of Community Health

Attachment H

1995-1997 Ambulatory Surgery Facilities Cost, Use, and Price Data
Top 50 Diagnostic Codes Ranked by 1997 Payments

Diag Code	General Description	% Chg/1000 Members Payments	% Chg/1000 Members Visits	% Chg Pymt/Visit	Avg/Pmt Visit	1995-97 Payments	% to Tot. Payout	1995-97 Visits	% to Tot. Visits
36610	Senile cataract, unspecified	-8.9%	-10.6%	1.6%	$1,779.92	$1,514,713	4.3%	851	2.8%
3669	Unspecified cataract	44.3%	40.8%	2.9%	$1,589.15	$1,287,211	3.6%	810	2.6%
470	Deviated nasal septum	-10.3%	-9.9%	-0.5%	$1,627.95	$854,675	2.4%	525	1.7%
38110	Infection of the middle ear, w/out pus	-23.6%	-27.3%	5.9%	$721.30	$763,857	2.2%	1,059	3.4%
36616	Nuclear sclerosis (elderly lens)	59.5%	63.8%	-1.7%	$1,729.50	$726,391	2.1%	420	1.4%
7350	Deformity, toe angles toward other toes	18.9%	34.6%	-9.9%	$1,688.92	$699,212	2.0%	414	1.3%
7354	Other hammer toe	13.1%	23.4%	-5.5%	$1,681.82	$689,547	2.0%	410	1.3%
7271	Bunion	10.6%	18.3%	-5.8%	$1,743.38	$568,342	1.6%	326	1.1%
6101	Diffuse cystic mastopathy	12.7%	16.3%	-4.5%	$1,217.44	$546,631	1.5%	449	1.5%
37430	Ptosis of eyelid, unspecified	1.5%	2.9%	0.1%	$1,420.34	$534,047	1.5%	376	1.2%
4740	Inflammation of tonsil & adenoids	-9.6%	-9.5%	0.4%	$1,101.44	$533,099	1.5%	484	1.6%
55090	Region of groin hernia	14.4%	19.6%	-4.1%	$1,380.41	$528,698	1.5%	383	1.2%
3540	Carpal tunnel syndrome	6.2%	8.5%	-2.3%	$804.49	$455,339	1.3%	566	1.8%
6111	Hypertrophy of breast	-14.6%	-6.2%	-8.6%	$2,407.24	$438,118	1.2%	182	0.6%
8360	Tear of medial cartilage of knee	-12.8%	-14.5%	2.1%	$1,587.10	$423,755	1.2%	267	0.9%
47410	Tonsils with adenoids	-21.3%	-19.5%	-2.2%	$1,058.43	$401,147	1.1%	379	1.2%
6118	Other specified disorders of breast	-8.5%	-1.2%	-7.4%	$2,767.95	$381,977	1.1%	138	0.4%
4732	Inflammation of the sinus cavities	-8.4%	-5.1%	-3.5%	$2,949.92	$380,540	1.1%	129	0.4%
7173	Degeneration of inter. semilunar cartilage	-17.8%	-18.5%	0.1%	$1,404.62	$377,842	1.1%	269	0.9%
61172	Lump or mass in breast	23.2%	15.4%	5.9%	$1,045.15	$339,674	1.0%	325	1.1%
6268	Other, uterine hemorrhage	-28.1%	-28.7%	1.0%	$1,039.87	$314,042	0.9%	302	1.0%
6208	Disorders of ovary/fall. tube/ligament	-12.3%	-14.1%	2.5%	$1,825.99	$306,935	0.9%	168	0.5%
36614	Posterior -polar senile cataract	-19.4%	-17.6%	-2.3%	$1,732.93	$279,002	0.8%	161	0.5%
36617	Total or mature cataract	14.1%	12.0%	1.6%	$1,799.84	$275,376	0.8%	153	0.5%
72673	Calcaneal spur (heal bone)	58.6%	72.9%	-12.4%	$1,624.08	$267,974	0.8%	165	0.5%
7177	Chondromalacia of patella	29.1%	29.7%	-0.5%	$1,406.83	$265,890	0.8%	189	0.6%
6262	Excessive or frequent menstruation	-18.0%	-18.3%	-0.6%	$1,038.40	$261,678	0.7%	252	0.8%
6146	Pelvic peritoneal adhesions	-0.5%	-5.8%	-1.1%	$2,036.46	$246,412	0.7%	121	0.4%
7018	Hypertrophic & atrophic skin cond.	46.8%	132.1%	-24.6%	$3,108.98	$233,173	0.7%	75	0.2%
6271	Postmenopausal bleeding	-2.4%	-1.2%	-1.5%	$984.05	$232,236	0.7%	236	0.8%
217	Benign neoplasm of breast	22.1%	24.4%	-4.8%	$1,153.01	$212,154	0.6%	184	0.6%
7380	Acquired deformity of nose	12.6%	25.5%	-9.2%	$1,856.89	$198,687	0.6%	107	0.3%
99654	Due to breast prosthesis	5.6%	2.9%	5.0%	$3,178.08	$187,507	0.5%	59	0.2%
6210	Polyp of corpus uteri	14.6%	4.5%	7.8%	$1,033.30	$178,761	0.5%	173	0.6%
7262	Other affections of shoulder region	42.1%	15.0%	26.9%	$2,107.63	$177,041	0.5%	84	0.3%
V252	Sterilization (fallopian tubes)	-4.2%	-6.4%	-0.7%	$833.11	$176,620	0.5%	212	0.7%
3556	Lesion of plantar nerve	14.3%	12.1%	-0.2%	$1,349.71	$170,063	0.5%	126	0.4%
2180	Benign, tumor- inner lining of the uterus	30.6%	30.1%	7.4%	$1,303.67	$169,478	0.5%	130	0.4%
7260	Adhesive capsulitis of shoulder	38.2%	-3.5%	44.2%	$1,589.39	$166,886	0.5%	105	0.3%
6221	Dysplasia of cervix	35.2%	29.8%	6.7%	$883.06	$164,249	0.5%	186	0.6%
2113	Colon Appendix	51.1%	60.5%	-13.2%	$393.90	$163,467	0.5%	415	1.4%
7172	Derangement of posterior horn of knee	12.1%	10.5%	1.6%	$1,514.18	$162,018	0.5%	107	0.3%
3668	Other cataract	1564.0%	1929.2%	-7.9%	$1,718.29	$159,801	0.5%	93	0.3%
37434	Disorder affecting eyelid function	15.8%	7.3%	10.7%	$1,989.68	$153,206	0.4%	77	0.3%
37487	Loss of elasticity- skin under eye sags	64.5%	77.9%	-9.9%	$2,018.51	$149,370	0.4%	74	0.2%
3829	Unspecified otitism media	30.6%	46.0%	-13.0%	$762.44	$133,428	0.4%	175	0.6%
72742	Ganglion of tendon sheath	43.0%	33.0%	3.1%	$795.03	$126,410	0.4%	159	0.5%
7576	Specified anomalies of breast	86.1%	139.7%	-7.7%	$2,702.34	$121,605	0.3%	45	0.1%
V501	Plastic surgery - unacceptable appear.	401.5%	284.4%	4.1%	$2,434.97	$87,659	0.2%	36	0.1%
52410	Unspecified anomaly	882.2%	435.4%	83.4%	$8,659.09	$69,273	0.2%	8	0.0%
	All Other Diagnostic Codes	1.5%	-0.3%	3.8%	$970.80	$17,077,428	48.3%	17,591	-57.2%
	Grand Total	3.4%	1.8%	2.5%	$1,149.73	$35,332,840	100.0%	30,730	100.0%

Attachment "B"

State of Michigan
John Engler, Governor

Department of Consumer & Industry Services
Kathleen M. Wilbur, Director

Attachment B
Insurance Bureau
Frank M. Fitzgerald, Commissioner

P.O. Box 30220
Lansing, Michigan 48909-7720
Toll Free (877) 999-6442
Lansing Area (517) 373-0220
Web site: www.cis.state.mi.us/ins

MEMORANDUM

DATE: February 23, 2000

TO: File

FROM: Brian Reed

SUBJECT: Summary of Ambulatory Surgical Facilities Provider Class Plan Testimony

On August 23, 1999 at approximately 9:30 am, the public hearing was called to order. Representing the Insurance Bureau were Susan M. Scarane, Director of Provider Class Plans and Brian Reed, graduate assistant to Susan Scarane. Approximately 35 people were in attendance on behalf of varied interests. Ms. Scarane provided a brief introduction as well as a review of the issues covered in the Notice of Hearing. All participants were invited to submit additional testimony regarding ambulatory surgical facilities and hospital provider class plans by October 31, 1999. Following the introduction, oral testimony regarding input on BCBSM's ambulatory surgical facilities was welcomed. At the start of the meeting, testimony cards were handed out. Oral testimony followed the order in which testimony cards were received. Provided in this memorandum is a brief summary of both the testimony presented at the public hearing and written testimony received throughout the review period. There was no oral testimony regarding the hospital provider class plan at the public hearing.

Summary of Arguments:

The first speaker was Floyd Goodman, M.D. Goodman stated that BCBSM's ASF provider class plan violated three statutory requirements of Public Act 350.

Goodman claims the ASF provider class plan did not meet the access goal set forth in the act because it participated with less than 50% of eligible ambulatory surgical facilities. Goodman states that BCBSM only participates with hospital owned ASFs, and only participates with freestanding ASFs when it is court ordered. Goodman states that BCBSM's Evidence of Need (EON) has denied ASFs even when they are granted certificates of need. Goodman also states that BCBSM's actions have lead to fewer procedures being done in ASFs. Only 30,000 procedures were done in ASFs from 1995-1997 while 600,000 were done in hospitals. Goodman feels that at least 70% of procedures can be done in an ASF.

Goodman also stated that ASFs offer a higher quality of care which BCBSM denies its members by using its EON criteria.

Goodman states that although BCBSM met the cost goal technically stated in the Act, the cost goal only encompasses reimbursement and does not take into account money that could be saved. Goodman states that participating with ASFs could save much more money.

The second speaker was Traci Messenger who represented her husband Greg Messenger, M.D. Messenger stated that he also believes that BCBSM is in violation of the three statutory goals. Messenger contends that BCBSM participates with less than 50% of ASFs and the 22 ASFs that BCBSM does participate with are all hospital owned. Messenger states this is contrary to BCBSM's policies in other states.

Messenger also states that the Greater Lansing Ambulatory Surgery Center (GLASCCO) received its certificate of need (CON) from the Michigan Department of Health based on 1000 surgical cases per operating room. However, BCBSM refused to participate with GLASCCO citing their EON criteria of 1,200 cases per operating room. Messenger states that BCBSM's claims that their EON is based on the same criteria as the CON. Messenger contends that GLASCCO was told BCBSM would not participate with them unless it was owned by a hospital. BCBSM continues to withhold the criteria used to deny GLASCCO. The Wayne County Circuit Court ordered a preliminary injunction that BCBSM could not exclude GLASCCO from participation.

Messenger contends that in Lansing, patients frequently have to wait 3 to 6 weeks for elective outpatient surgery in the local hospitals. Messenger further contends that BCBSM's position that "3 to 6 weeks does not appear to be excessively long" is not acceptable.

Messenger went on to illustrate how BCBSM fails to satisfy the cost goal. He stated that BCBSM increases their premiums at 300 to 500% the national rate of increase. Despite health care costs skyrocketing in Michigan, BCBSM continues to pay hospital owned ASFs 23% more than freestanding ASFs for the same procedures. By participating with freestanding ASFs, Messenger feels that these costs will come back into reason.

Messenger also states that ASFs offer a greater quality of care. Messenger points out that there are statistically less nosocomial infections in freestanding ASFs than in hospitals.

The third speaker was Julie L. Lester, Director of Medical Economics and Health Care Delivery for the Michigan State Medical Society. Lester expressed concern over the fact that BCBSM has declined to participate with freestanding ASFs citing their EON process. Despite the fact that these ASFs have met the state of Michigan's CON, they do not meet BCBSM's EON requirements which remain unknown. These freestanding ASFs have not been able to get information on why they are denied from BCBSM.

In addition, Lester argues that BCBSM says that freestanding ASFs will increase health care costs by creating excess capacity. However, Lester contends that freestanding ASFs are reimbursed at a lower rate than hospital outpatient departments. By providing the same services at a lower price, Lester contends that money would be saved thereby decreasing costs to the consumer. Lester states that BCBSM's policies are contradictory to cost

containment concerns. Lester also asks whether hospitals and hospital owned ASFs are being held to the same criteria as physician sponsored ASFs.

The fourth speaker was Robert Wolford, CEO of Surgical Care Center of Michigan. Wolford stated that he represents four licensed ASFs. He is interested in working with BCBSM but feels that BCBSM is being unreasonable.

Wolford stated that BCBSM's EON is unsatisfactory. Wolford contends that BCBSM has no intention of approving freestanding ASFs. In addition, Wolford asserts that BCBSM will not give him any information on why freestanding ASFs are denied participation.

Wolford claims that BCBSM has engaged in discrimination against ASFs and acted to protect hospitals. Wolford gives the example of Spectrum Health-Ferguson Center. Ferguson added 4 operating rooms in 1996 even though other rooms are underutilized. This further diluted the cases per operating room in this service area making it impossible for freestanding ASFs to meet BCBSM's EON of 1,200 cases per room.

The fifth speaker was Linda Kirk of Grand Valley Surgical Center. Kirk echoed the concerns of Robert Wolford that BCBSM was discriminating against non-hospital owned ASFs. Kirk contends that hospital owned ASFs do not have to meet the same EON criteria that freestanding ASFs have to meet. Consequently, hospital owned ASFs continue to add rooms further diluting the cases per room, making it harder for non-hospital ASFs to meet BCBSM's EON criteria.

The sixth speaker was Charles D. Dobis of the Michigan Surgical Center. Dobis claims that ASFs play a bigger role in other states. Dobis also states that most other carriers cover ASFs, but BCBSM continues not to do so.

Dobis also says BCBSM's concerns regarding excess utilization if they were to participate with freestanding ASFs is unfounded. Dobis contends that there is no correlation between utilization and capacity. Dobis says many times, there is a decrease as is the case if cataract surgery rates are compared between hospitals and ASFs.

Speaker seven was Robert Barber of Brookside Surgery Center. Barber stated that BCBSM in essence has established a monopoly for hospitals with their EON criteria. In effect, subscribers are denied access to lower costing ASFs and consequently access to new and useful technology.

The eighth speaker was Michael Richmond of the Surgery Center of Michigan. Richmond echoed the concerns of the previous speakers and gave some examples. One example was how BCBSM told him flat out that they would not give out BCBSM numbers to non-BCBSM ASFs. All ASFs are rejected immediately by BCBSM, however, BCBSM refuses to release data or reasoning for these denials.

Linda Fausey representing Blakewoods and SCM Surgery Center spoke ninth.

Ms. Fausey expressed concerns over the EON process. She felt the EON is unfair and used by BCBSM to monopolize the market. She felt the EON negates the ASFs license to operate

and their CON. Ms. Fausey feels the Act does not allow BCBSM to establish their EON. She feels this is the responsibility of the MDCH.

Ms. Fausey also questioned the constitutionality of the Act in general and many of the definitions within the Act. She stated that Part 5 has never been reviewed for constitutionality. She does not feel that the Act allows BCBSM to establish "licensure standards."

Ms. Fausey also claimed that BCBSM uses the EON to monopolize the market. She stated it is 50% cheaper to get care at an ASF as opposed to a hospital. She feels that BCBSM should not be deciding capacity for ASFs because ASFs are not in a position to cost-load. She further states that there is no evidence of over-utilization since BCBSM has never participated with ASFs.

The tenth speaker was Louise Kirk from Wachler and Associates. Kirk first read a statement by Dr. Francis P. Welsh of the Upper Peninsula, and then she spoke for the Genesis Surgery Center and Superior Endoscopy Center.

Ms. Kirk testified that BCBSM did not meet the access goal of the Act because they participate with less than 50% of ASFs. In addition, BCBSM does not participate with any ASFs in the Upper Peninsula and it only participates with one physician owned ASF in the state.

Ms. Kirk further testified that BCBSM uses the EON to discriminate against physician owned ASFs. Ms. Kirk also states that BCBSM does not communicate how ASFs can meet the EON. In addition, BCBSM does not explain to the denied ASFs why they did not meet the EON. BCBSM refuses to explain or describe its service area or rate of surgery/population. Ms. Kirk states that BCBSM violates section 502(8) of the Act because the denied ASFs are licensed and meet reasonable standards, yet BCBSM still refuses to participate.

Ms. Kirk also feels that the multi-specialty requirement is illogical. Medicare and other payors pay ASFs with only one specialty. Kirk also states that EON and the multi-specialty requirement do not have anything to do with quality. Ms. Kirk states that BCBSM could save money by participating with centers of excellence and also eliminating the EON criteria.

Kirk concluded by saying that cost containment is very important in health care today. ASFs save costs, so why doesn't BCBSM participate with more ASFs.

The 11th speaker was Fernando Bermudez, M.D. of the Eastside Endoscopy Center. Bermudez claims that BCBSM violates the goals for quality of care in a couple ways. First, by requiring that ASFs be specialized in 5 different areas, it excludes those ASFs that specialize in one type of procedure. Second, BCBSM ignores many of the technological advances that have allowed changes in the delivery of ambulatory services. Bermudez claims that BCBSM has ignored the fact that ambulatory surgical procedures can be performed in ASFs at a higher efficiency while also improving on the quality of care.

Bermudez also claims that BCBSM violates the access clause of the Act by refusing to participate with freestanding ASFs, resulting in a lack of access for BCBSM subscribers. In addition, Bermudez contends that BCBSM is perpetuating higher costs for health care. By refusing to participate with freestanding ASFs, BCBSM is simply not letting free enterprise

take its course and letting ASFs compete. BCBSM is content paying the higher costs that hospitals require.

In addition to the testimony presented at the public hearing, a great deal of written testimony was also provided to the Bureau.

There was in excess of 500 form letters submitted to the Bureau from patients that had elected to have surgeries performed at ASFs. These letters attested to the low cost and quality of physician owned ASFs and requested the Bureau find BCBSM in violation of the Act and force BCBSM to participate with these ASFs.

Employees of the Superior Endoscopy Center in Marquette, Michigan also submitted a series of other form letters. These letters posed a series of questions that the employees felt should be asked towards BCBSM.

The following individuals also submitted written testimony that basically addressed the same issues as the various testimonies described herein:

Phyllis J Rutledge, RN
Lowell R. Fisher, D.O.
Edward J. Nebel, M.D.
Mark D. Russell, D.O.
Richard Goodney
John G. Bizon, MD, F.A.C.S.
Representative Mark H. Schauer
Dan L. Hunt, D.O., F.A.C.O.S.
Mark W. Jones, D.O., F.A.C.O.S.
Suzanne M. Hanses, D.O.
Melissa S. Richardson, D.O.
Thomas D. LeGalley, M.D.
Edward J. Brophy, D.O.
Ronald L. Clark, M.D.
Norman J. Licht, M.D.
Joseph M. McGraw, M.D.
G. Barry Wickstrom, M.D.
W. John Bruder, M.D.
Michael J. Forness, D.O.
David S. Lint, M.D.
Vincent R. Prusick, M.D.
John M. Nassif, M.D.
Larry M. Vander Plas, M.D.
Lou Ann Balding
Laura Farnsworth
Gerald R. Peterson
James R. Kesler
Kathy Bryant
William F. Weatherhead, D.O., F.A.C.O.I
Federated Ambulatory Surgery Assoc.
Kristine A. Gorsalitz, R.N., D.O.N.
Thomas F. Huffman, M.D.
Francis P. Welsh, M.D.
John G. Kublin, M.D.
Dennis A. Herzog, M.D.
Richard E. Vermeulen, M.D.
Douglas R. Shearer, M.D.
Jeffrey P. Shaffer
Clemon Pardales, D.O.
Brian E. Helmer, M.D.
Gary L. Walker
Hugh M. Miller
Jeff Colquhoun, M.D.
Larry L. Pack
Pam Dietrich
David A. Detrisac, M.D.
Senator John J.H. Schwarz, M.D.
Bill Hetrick
Donald R. Bohay, M.D.
James L. Keller, M.D.
Krishna K. Sawhney, M.D.
Gregory Uitvlugt, M.D.
Kenneth E. Stephens, Ph.D., D.O.
Laith A. Farjo, M.D.
Larry A. Wickless, D.O.
Cynthia A. Nyquist RN, BSN
Judy Creech, RN
John F. Walling, Jr., D.O.

Gail Albright
Brian Goupil, LPN
Angela R. Farnsworth
Cynthia D. Konken
Peter Keast
Jane Beshore
Marilyn H. Bell

In addition, The Michigan Health and Hospital Association (MHA) submitted written testimony supporting BCBSM performance in the goals stated in the Act. The MHA testified that the EON criteria merely prevents an oversupply of operating rooms in a given service area which in turn keeps overall health care costs down. The MHA supports the EON because the cost of procedures remaining at hospitals would increase if a large portion of outpatient procedures were transferred to other facilities. The MHA feels that BCBSM has met the access, quality and cost goals stipulated in the Act. The MHA states that the EON requirement is a fair assessment of the need for operating rooms. The MHA is especially concerned about the impact that more liberalized EON criteria would have on hospitals. Hospitals must maintain certain overhead such as 24-hour services and access to all patients regardless of ability to pay and losing some outpatient procedures would place a burden on the hospital system. The MHA further claims that hospitals participate with BCBSM and grant substantial discounts from listed charges in anticipation of supplying a certain volume of services to patients. Any "carve-outs" of services that are taken away from the hospitals threaten the future of BCBSM's participating hospital agreement.

BCBSM also submitted testimony. BCBSM defended its performance on the goals stating that they have met the access, quality and cost goals. BCBSM contends that the EON requirement is a reasonable requirement and does not act in a licensing capacity or to duplicate the State's CON process. BCBSM also argues that Michigan is not an "Any Willing Provider" state. Therefore, BCBSM is not obligated to participate with every ASF that has a license. BCBSM also states in its testimony that is is only obligated to cover facility services at participating ASFs and non-participating facility charges are not covered.

BCBSM further claims they do not discriminate against ASFs on the basis of ownership. BCBSM points out that they participate with three physician owned ASFs: Greater Lansing Ambulatory Surgery Center, Toledo Clinic and HealthCare Midwest Surgery Center.

BCBSM also denies that its policies increase costs for BCBSM members. BCBSM states that on average, outpatient hospital departments are reimbursed about 23% higher than freestanding ASFs because of the greater overhead costs associated with hospitals. Overhead includes the different expenses unique to hospitals such as graduate medical education, uncompensated care, bad debt, capital expenditures, and other expenses associated with operating 7 days a week, 24 hours a day. BCBSM contends that along with its members, it has a vested interest in ensuring that hospitals remain solvent so it can continue to serve the community. BCBSM further states that rate increases were mainly the result of increases in prescription drugs, office visits and health care trends. BCBSM claims the fact that it achieved the cost goal for 1996-1997 is evidence that its policies on ASFs contained costs rather than increase them.

BCBSM Evidence of Need Requirement for Ambulatory Surgical Facilities

EON reviews are calculated for a service area (generally a county), using statistical information from the State of Michigan. The steps used to perform each review are as follows:

Step 1: The number of operating rooms, both inpatient and outpatient, available in the applicable service area is calculated.

Step 2: The number of available operating rooms is multiplied by 1200 to determine overall surgical capacity in the service area.

Step 3: The number of surgical procedures, both inpatient and outpatient, actually performed in the applicable service area is calculated.

Step 4: The overall capacity calculated in Step 2 is compared to the number of surgical procedures calculated in Step 3.

- If the overall capacity exceeds the number of surgical procedures performed, then additional outpatient surgical capacity to serve BCBSM members is determined unnecessary and the EON requirement has not been met.

- If the number of surgical procedures performed exceeds the overall capacity, then there is an indicated need for additional capacity to serve BCBSM members, and the EON requirement has been met.

In addition to the steps listed above, EON can also be achieved if the addition of a participating ASF does not result in an addition to OR capacity in the service area. A typical example of EON of this type is when a provider agrees to close a number of OR's at one facility in the same service area, which is greater than, or equal to the number of OR's it is opening at the ASF.

The EON requirement is just one of a number of participation requirements that a facility must meet to be eligible for reimbursement by BCBSM. To be considered for participation, all facilities must submit a completed application, and meet all requirements.

BCBSM Evidence of Need Requirement For Ambulatory Surgical Facilities (Used until January 1998)

Step 1: Determine Current Demand.

$N = P * R$

Where:

N = Need for outpatient operating rooms in service area
P = Population of service area
R = Rate of surgery per population (hospital and ASFs)

Step 2 Determine Current Capacity.

$C = O * S$

Where:

C = Current Capacity
O = Number of Operating room suites in service area
S = Surgeries per operating room suite per year

Step 3: Determine if additional operating rooms are needed.

$X = N - C$

Where:

X = Additional operating rooms needed
N = Need
C = Capacity

If capacity is greater than need, additional outpatient surgical capacity is unnecessary.

BCBSM EON Calculations

Facility	County	Data Source	Procedures	Demand (Need)	Existing Rooms	Over/(Under) Capacity
Blakewoods	Jackson	1996	22,137	18	19	1
Michigan Surgery Center	Ingham	1996	53,478	45	52	7
Genesis Surgery Center	Ingham	1996	53,478	45	52	7
Oakland Surgl Center	Oakland	1995	128,563	107	130	23
Garrett Eye Center	Iron	1995	384	1	3	2
Grand Valley Surgical Center	Kent	1996	72,001	60	77	17
Mercy Memorial	Monroe	1994	9,006	8	8	0
Upper Peninsula Surgery Center	Marquette	1994	9,683	8	13	5
Genesys Health System	Genesee	1994	46,561	39	52	13

Data Source: Michigan Department of Community Health, Annual Hospital Statistical Questionnaire

Attachment E

Attachment F

EON DETERMINATION FOR BORGESS MEDICAL CENTER IN PORTAGE, MI
February 16, 1996

The EON calculation for the Borgess Medical Center located in Portage, MI is based on need in the three counties neighboring Kalamazoo county. The service area for this facility can reasonably be expected to serve patients these three counties: Cass, St. Joseph, and Van Buren. Kalamazoo county itself does not currently demonstrate need. All calculations are based the 1994 ASF EON calculations, which utilize 1993 data.

County	(1) # of facilities in cty.	(2) # of O/R's in each county	(3) Less one O/R for each facility that treats E/R & trauma & trauma patients	(4) Net O/Rs (2) - (3)	(5) 1,000 cases/ O/R	(6) Total Capacity (4) * (5)
Cass	1	3	1	2	1,000	2,000
St. Joseph	2	5	2	3	1,000	3,000
Van Buren	2	4	2	2	1,000	2,000
TOTAL		12	5	7		7,000

County	(1) Actual Volume	(2) Total Capacity	(3) Actual Volume less Total Capacity (1) - (2)
Cass	1,612	2,000	-388
St. Joseph	2,844	3,000	-156
Van Buren	2,590	2,000	590
TOTAL	7,046	7,000	46

1995 ASF EON CALCULATION
(based on 1994 data)

County	CURRENT USE: Current Use (Procedures)	Current Use (Patients)	Total Use	CURRENT CAPACITY: (1) # O/R Rooms	(2) Surg./ Room/ Year	(3) Current Capacity (1) * (2)	Current Use minus Capacity
Kalamazoo	28,109	1009	29,118	41	1,000	41,000	-11,882

(a) 1/1/95 Population	(b) Surg. rate per population	(c) Est. Need (a * b)	(d) Current Capacity	(e) Est. Need minus Capacity (c) - (d)
229,300	0.10	22,930	41,000	-18,070

Sources

CURRENT USE:

(1) Consists of I/P and O/P procedures for hospitals and # of procedures for the remaining ASFs.

# of I/P & O/P Procedures for hospitals = (Source: 1995 Annual Hospital Survey - Table 5 MI Dept. of Public Health)	21,945
# of O/P procedures for ASFs = (Source: Phone call to facility)	7,173
TOTAL	29,118

CURRENT CAPACITY:

(1) 1994 Annual Hospital Survey: Table 5 - Surgical Room Services (MI Dept. of Public Health). # of surgical suites for ASFs was determined by calling each ASF.

(2) Taken from earlier versions of ASF EON calculation papers.

OTHER:

(a) 1/1/95 Population - Sales & Marketing Management -1995 Survey of Buying Power. BCBSM Corporate Library (F. Palmer).

(b) American Hospital Assoc.: St. of MI - Table 5C (94/95). Ph. # (312) 422-3000.

199[illegible] ON Data

Ambulatory Surgical Center	Ownership	Number of O/R	Number of Surgical Cases	CON/EON Criteria (Divided by 1200)	Meet CON? Currently
Blakewoods	Physician	2	2601	2.1675	Yes
Lansing Surgery Center, Llc (formerly GLASSCO)	Physician	3*	2646	2.2050	No
Jackson Outpatient Surgery Center	Hospital	5*	6396	5.3300	Yes
St. John Surgery Center	Hospital	4	4367	3.6392	No
Harper-Hutzel Hlth Ctr Warren	Hospital	2	1189	0.9908	No
Mercy Mem Comm Hlth Ctr	Hospital	3*	1701	1.4175	No
Sinai Surgery Center	Hospital	4	4777	3.9808	No
Community Surgical Center	Hospital	2*	992	0.8267	No
Providence Medical Center ASC	Hospital	3	3643	3.0358	Yes
Grace Hospital ASC	Hospital	4*	3772	3.1433	No
Providence Surgical Center	Hospital	3	2161	1.8008	No
Waterford Ambulatory Health Services	Hospital	2	1700	1.4167	No
Oakwood Healthcare Ctr - Dearborn	Hospital	2	2306	1.9217	No
University of Michigan Surgery Center	Hospital	4	1547	1.2892	No
Battle Creek Health System	Hospital	4	1762	1.4683	No
Health Care Midwest Surgery Center	Physician	1	1323	1.1025	Yes
Borgess Surgery/Woodbridge Hills	Hospital	4*	1492	1.2433	No
Butterworth Hlth Pavilion-South	Hospital	2	2702	2.2517	Yes
Spectrum Health Surgical Center	Hospital	6	6890	5.7417	No
Genesys Amb Surgerical Cter at Hlth Pk	Hospital	4*	3757	3.1308	No
Saginaw General North	Hospital	5	3752	3.1267	No
St. Mary's Amb Care Ctr	Hospital	5*	4043	3.3692	No
Garrett Eye Ctr	Physician	2	535	0.4458	No
Genesis Center, P.L.C.	Physician	5*	1264	1.0533	No
Oakland Surgi Center	Physician	2	950	0.7917	No
Upper Penninsula Surgery Center	Physician	4	925	0.7708	No
Brookside Surgery Center	Physician	3	1787	1.4892	No
Grand Valley Surgery Center Llc	Physician	4	1790	1.4917	No
Michigan Surgical Center	Physician	4	1307	1.0892	No
Surgery Center of Michigan	Physician	2	1500	1.2500	No

* - Includes Endoscopy Rooms and Endoscopy Surgical Cases

Preliminary Data taken from the 1998 Annual Freestanding Surgical Facility Questionnaire - Michigan Department of Community Health

Attachment H

1995-1997 Ambulatory Surgery Facilities Cost, Use, and Price Data
Top 50 Diagnostic Codes Ranked by 1997 Payments

Diag Code	General Description	% Chg/1000 Members Payment	% Chg/1000 Members Visits	% Chg Pymt/Visit	Avg/Pat Visit	1995-97 Payment	% to Tot Payment	1995-97 Visits	% to Tot Visits
36610	Senile cataract, unspecified	-4.9%	-10.5%	1.6%	$1,779.92	$1,514,713	4.3%	851	2.8%
3669	Unspecified cataract	44.3%	40.3%	2.9%	$1,569.15	$1,287,211	3.6%	810	2.6%
470	Deviated nasal septum	-10.3%	-9.9%	-0.5%	$1,627.95	$854,575	2.4%	525	1.7%
38110	Infection of the middle ear, w/out pus	-23.6%	-27.3%	5.9%	$721.30	$763,857	2.2%	1,059	3.4%
36616	Nuclear sclerosis (elderly lens)	59.5%	63.8%	-1.7%	$1,729.50	$726,391	2.1%	420	1.4%
7350	Deformity, toe angles toward other toes	16.9%	34.6%	-9.9%	$1,686.92	$699,212	2.0%	414	1.3%
7354	Other hammer toe	13.1%	23.4%	-5.5%	$1,661.82	$689,547	2.0%	410	1.3%
7271	Bunion	10.6%	18.3%	-5.8%	$1,743.38	$568,342	1.6%	326	1.1%
6101	Diffuse cystic mastopathy	12.7%	16.3%	-4.5%	$1,217.44	$546,631	1.5%	449	1.5%
37430	Ptosis of eyelid, unspecified	1.5%	2.9%	0.1%	$1,420.34	$534,047	1.5%	376	1.2%
4740	Inflammation of tonsil & adenoids	-9.6%	-9.5%	0.4%	$1,101.44	$533,099	1.5%	484	1.6%
55090	Region of groin hernia	14.4%	19.6%	-4.1%	$1,380.41	$528,698	1.5%	383	1.2%
3540	Carpal tunnel syndrome	6.2%	8.5%	-2.3%	$804.49	$455,339	1.3%	566	1.8%
6111	Hypertrophy of breast	-14.6%	-6.2%	-8.6%	$2,407.24	$438,118	1.2%	182	0.6%
3360	Tear of medial cartilage of knee	-12.6%	-14.5%	2.1%	$1,587.10	$423,755	1.2%	267	0.9%
47410	Tonsils with adenoids	-21.3%	-19.5%	-2.2%	$1,058.43	$401,147	1.1%	379	1.2%
6118	Other specified disorders of breast	-8.5%	-1.2%	-7.4%	$2,767.95	$381,977	1.1%	138	0.4%
4732	Inflammation of the sinus cavities	-6.4%	-5.1%	-5.8%	$2,949.92	$380,540	1.1%	129	0.4%
7173	Degeneration of inter. semilunar cartilage	-17.8%	-16.8%	-0.1%	$1,404.62	$377,842	1.1%	269	0.9%
61172	Lump or mass in breast	23.2%	15.4%	5.9%	$1,045.15	$339,674	1.0%	325	1.1%
6268	Other, uterine hemorrhage	-25.1%	-25.7%	1.0%	$1,039.37	$314,042	0.9%	302	1.0%
6208	Disorders of ovary/fall. tube/ligament	-12.3%	-14.1%	2.5%	$1,526.99	$306,935	0.9%	168	0.5%
36614	Posterior -polar senile cataract	-19.4%	-17.6%	-2.3%	$1,732.93	$279,002	0.8%	161	0.5%
36617	Total or mature cataract	14.1%	12.0%	1.6%	$1,799.84	$275,376	0.8%	153	0.5%
72673	Calcaneal spur (heal bone)	58.5%	72.9%	-12.4%	$1,624.08	$257,974	0.8%	165	0.5%
7177	Chondromalacia of patella	29.1%	29.7%	-0.5%	$1,406.83	$265,890	0.8%	189	0.6%
6262	Excessive or frequent menstruation	-18.0%	-18.3%	-0.6%	$1,038.40	$261,578	0.7%	252	0.8%
6146	Pelvic peritoneal adhesions	-0.5%	-5.8%	-1.1%	$2,036.46	$246,412	0.7%	121	0.4%
7018	Hypertrophic & atrophic skin cond.	46.8%	132.1%	-24.6%	$3,108.98	$233,173	0.7%	75	0.2%
6271	Postmenopausal bleeding	-2.4%	-1.2%	-1.5%	$984.05	$232,236	0.7%	236	0.8%
217	Benign neoplasm of breast	22.1%	24.4%	-4.8%	$1,153.01	$212,154	0.6%	184	0.6%
7380	Acquired deformity of nose	12.6%	25.5%	-9.2%	$1,656.89	$198,687	0.6%	107	0.3%
99654	Due to breast prosthesis	5.6%	2.9%	5.0%	$3,178.06	$187,507	0.5%	59	0.2%
6210	Polyp of corpus uteri	14.6%	4.5%	7.8%	$1,033.30	$178,761	0.5%	173	0.6%
7262	Other affections of shoulder region	42.1%	15.0%	26.9%	$2,107.63	$177,041	0.5%	84	0.3%
V252	Sterilization (fallopian tubes)	-4.2%	-6.4%	-0.7%	$833.11	$176,620	0.5%	212	0.7%
3556	Lesion of plantar nerve	14.3%	12.1%	-0.2%	$1,349.71	$170,063	0.5%	126	0.4%
2180	Benign, tumor- inner lining of the uterus	30.6%	30.1%	7.4%	$1,303.67	$169,478	0.5%	130	0.4%
7260	Adhesive capsulitis of shoulder	38.2%	-3.5%	44.2%	$1,569.39	$166,886	0.5%	105	0.3%
6221	Dysplasia of cervix	35.2%	29.8%	-6.7%	$883.06	$164,249	0.5%	186	0.6%
2113	Colon Appendix	51.1%	60.5%	-13.2%	$393.90	$163,467	0.5%	415	1.4%
7172	Derangement of posterior horn of knee	12.1%	10.5%	1.6%	$1,514.18	$162,018	0.5%	107	0.3%
3668	Other cataract	1564.0%	1929.2%	-7.9%	$1,716.29	$159,801	0.5%	93	0.3%
37434	Disorder affecting eyelid function	15.8%	7.3%	10.7%	$1,989.68	$153,206	0.4%	77	0.3%
37487	Loss of elasticity- skin under eye sags	64.5%	77.9%	-9.9%	$2,018.51	$149,370	0.4%	74	0.2%
3829	Unspecified otitism media	30.6%	46.0%	-13.0%	$762.44	$133,428	0.4%	175	0.6%
72742	Ganglion of tendon sheath	43.0%	33.0%	3.1%	$795.03	$126,410	0.4%	159	0.5%
7576	Specified anomalies of breast	86.1%	139.7%	-7.7%	$2,702.34	$121,605	0.3%	45	0.1%
V501	Plastic surgery - unacceptable appear.	401.5%	284.4%	4.1%	$2,434.97	$87,659	0.2%	36	0.1%
52410	Unspecified anomaly	882.2%	435.4%	83.4%	$8,659.09	$69,273	0.2%	8	0.0%
	All Other Diagnostic Codes	1.5%	-0.3%	3.8%	$970.80	$17,077,428	48.3%	17,591	57.2%
	Grand Total	3.4%	1.8%	2.5%	$1,149.78	$35,332,840	100.0%	30,730	100.0%

Attachment "C"

Attachment C

STATE OF MICHIGAN
DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES
OFFICE OF FINANCIAL AND INSURANCE SERVICES

BLAKEWOODS SURGERY CENTER, L.L.C., JACKSON MEDICAL SERVICES, INC., PAUL ERNEST, M.D., KEVIN LAVERY, M.D., ANTHONY SENSOLI, M.D., SIGMUND ANCEREWICZ, M.D., KHAWAJA IKRAM, D.O., SHARON ROONEY-GANDY, D.O., ARTHUR WIERENGA, M.D., MARTIN PATRIAS, M.D., MICHAEL CHAMES, M.D., GHULUM DASTGIR, M.D., AND KABINDRA MISHRA, M.D.

Petitioners Docket No. 20001023

VISION INSTITUTE OF MICHIGAN SURGERY CENTER, P.C., LAURENCE LOEWENTHAL, M.D., AND JAY NOVETSKY, M.D.,

Petitioners Agency No. 00-234-BC

v

MICHIGAN COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES, FRANK FITZGERALD, in his official capacity,

Respondent A.G. No. 2000056980

In the matter of the Ambulatory Surgical Facility Provider Class Plan Determination Report and Order Pursuant to P.A. 350 of 1980

_____/

FINDINGS AND ORDER GRANTING RESPONDENT'S MOTION IN LIMINE AND AFFIRMING THE COMMISSIONER'S ORDER ISSUING DETERMINATION REPORT DATED MARCH 30, 2000

Issued and entered
this 29 day of November, 2000

PRESENT: HON. JAMES K. NICHOLS
Independent Hearing Officer

The Independent Hearing Officer (IHO) makes the following findings:

1. On July 6, 1999, the Respondent Commissioner (Commissioner) issued an Order which provided written notice of his intent to make a determination of the Ambulatory Surgical Facilities Provider Class Plan (Plan) pursuant to MCL 550.1509(1). The purpose of the Commissioner's review was to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) had substantially achieved the goals of the corporation as provided in MCL 550.1504 and achieved the objectives in the Plan. (See Exhibit 1.)

2. On March 30, 2000, pursuant to MCL 550.1509, the Commissioner issued his "Order Issuing Determination Report" relative to the Plan. Pursuant to MCL 550.1510(1), the Commissioner concluded that BCBSM failed to meet the access goal because BCBSM only achieved a formal participation rate of 36% of the Ambulatory Surgery Facilities located in the State. The Commissioner also concluded that BCBSM's standards for participation were unreasonable and not uniformly applied which affected the access goal. (See p. i, Exhibit 2.)

3. The Commissioner also concluded that BCBSM did not meet the quality of care goal because: (a) BCBSM did not review or recertify Ambulatory Surgery Facilities once participation was granted; (b) BCBSM's audit process for Ambulatory Surgery Facilities was deficient; and (c) BCBSM did not communicate its quality standards clearly to providers. (See p. i and pp. 22-31, Exhibit 2.)

4. However, the Commissioner did find that BCBSM met the cost goal as set forth in the formula found in MCL 550.1504(1)(c). (See p. ii and pp. 31-37 of Exhibit 2.)

5. As a result of these findings, the Commissioner required BCBSM to submit a new Ambulatory Surgical Facilities Provider Class Plan that substantially achieves the objectives and substantially overcomes the deficiencies enumerated in his Order. (See p. i, Exhibit 2.)

6. On May 1, 2000, the Petitioners filed their "Joint Petition for Review." In their Petition, they alleged that the Commissioner erred when he found that BCBSM met the cost goal because the Commissioner did not first determine reasonable cost. The Petitioners also alleged that the Plan was *ultra vires* because it provided that Ambulatory Surgical Facilities had to meet an Evidence of Need standard established by BCBSM. Finally, Petitioners alleged that BCBSM failed to recognize the Petitioners' license.

7. On October 19, 2000, the Commissioner filed a Motion in Limine with Brief in Support requesting that the Petitioners' witnesses be excluded from testifying because the issues on appeal were legal issues which were within the exclusive authority of the Independent Hearing Officer. Furthermore, the Motion argued that the testimony of these witnesses was irrelevant and immaterial and in some cases, the alleged expert witnesses were not qualified to give expert opinions.

8. On October 23, 2000, both the Petitioners and the Commissioner filed their respective Pretrial Briefs pursuant to the IHO's Order of August 22, 2000. Each Brief addressed the issues raised in the Petitioners' Joint Petition for Review.

9. On October 26, 2000, the Petitioners filed their Answer with Brief in Support, to the Commissioner's Motion in Limine.

10. On October 30, 2000, oral argument was held on the Commissioner's Motion in Limine. The Respondent argued that the issues raised by the Petitioners in their Joint Petition for Review were legal issues to be resolved by the IHO.

11. The IHO has heard the arguments and read all of the material submitted by the parties including the Commissioner's decision dated March 30, 2000. (See Exhibit 2.)

12. The issues raised by the Petitioners in their Joint Petition for Review are legal issues which are exclusively within the authority of the IHO. Therefore, no testimony need be taken to resolve those legal questions.

13. Furthermore, the substance of the testimony to be given by Petitioners' witnesses, based upon Petitioners' answers to the Commissioner's interrogatories, indicates that such testimony is not relevant or material to the issues on appeal. As a result, such testimony is excluded as being irrelevant and immaterial.

14. In particular, the proposed testimony of Petitioners' expert witness Bruce Hansen, as set forth in his deposition testimony and in his Affidavit, is based upon his interpretation of the meaning of MCL 550.1504(1)(c). Mr. Hansen erroneously concluded that this statute required the Commissioner to determine what was a reasonable cost for outpatient surgery and use that data in the formula set forth in such statute. This was an erroneous legal interpretation by Mr. Hansen. MCL 550.1504(1)(c) does not require the Commissioner to first determine what is a reasonable cost. This statute simply requires the Commissioner to determine whether the rate of change in the total corporation payment per member to the Ambulatory Surgical Facilities Provider Class is not higher than the compound rate of inflation and real economic growth. The Commissioner properly made this calculation, and found that BCBSM met the cost goal. (See pp. 31-37 of Exhibit 2.)

15. The Commissioner properly concluded that BCBSM could have reasonable Evidence of Need standards applicable to all licensed Ambulatory Surgical Facilities who wish to participate with it. (See pp. 13-14 of Exhibit 2, *Glasco v BCBSM*, Court of Appeals Docket No. 206415, issued April 13, 1999 and *Blakewoods et al v BCBSM*, Court of Appeals Docket No. 213666, issued July 14, 2000.

16. The Commissioner correctly decided that BCBSM need not reimburse every licensed Ambulatory Surgical Facility. BCBSM is not required to participate with every licensee. (See p. 14 of Exhibit 2 and MCL 550.1502(1)).

17. The Commissioner required BCBSM to re-write the Plan so that its Evidence of Need standards would be reasonable, and all licensed Ambulatory Surgical Facilities would have an equal opportunity to participate with BCBSM

because the Evidence of Need standards to be applied by BCBSM would apply fairly to all licensed Ambulatory Surgical Facilities, whether owned by a hospital or owned by a doctor. (See pp. 21-22, 29-31, and 37-38 of Exhibit 2.)

18. Thus, the issues raised by the Petitioners as set forth in the foregoing Paragraphs 14 through 17 are legal issues which the Commissioner properly resolved in his Decision of March 30, 2000.

THEREFORE, IT IS HEREBY ORDERED that, for the reasons stated on the record and set forth herein: (a) the Commissioner's Motion in Limine is granted. As a result, Michael J. Klecha, Bruce Hansen, Bob Williams, Michael Richmond, and Dr. Kevin Lavery are excluded as witnesses; and, (b) the Commissioner's Decision is AFFIRMED.

James K. Nichols

HONORABLE JAMES K. NICHOLS
Independent Hearing Officer

PROOF OF SERVICE

I hereby state, to the best of my knowledge, information and belief, that a copy of the foregoing document was served upon all parties and/or attorneys of record in this matter by Inter-Departmental mail to those parties employed by the State of Michigan and by UPS/Next Day Air, facsimile, and/or by mailing same to them via first class mail and/or certified mail, return receipt requested, at their respective addresses as disclosed by the file on the 15th day of December, 2000.

J. R. Peoples
J. R. Peoples
Bureau of Hearings

Larry F. Brya
Department of Attorney General
Insurance and Banking Division
525 West Ottawa Street
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Division of Insurance
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Attachment "D"

Blue Cross
Blue Shield
of Michigan

Attachment D

600 Lafayette East
Detroit, Michigan 48226-2998

December 29, 2000

Ms. Susan M. Scarane
Department Specialist
Health Plan
Office of Policy and Consumer Services
Division of Insurance
611 West Ottawa Street
Lansing, Michigan 48933

Re: Ambulatory Surgical Facilities

Dear Ms. Scarane:

Enclosed for filing is Blue Cross Blue Shield of Michigan's (BCBSM) remedial provider class plan for ambulatory surgical facilities. This plan, which is being filed pursuant to Section 511 of Public Act 350, addresses the deficiencies identified by the Insurance Commissioner in his March 30, 2000, Determination Report. The plan and contract were finalized after BCBSM obtained input from providers, subscribers and bureau staff. For your reference, I have also enclosed the position paper that you reviewed.

Absent a court order or some other mandate staying the plan's implementation, BCBSM intends to implement this plan after it is retained, even if its retention is appealed by another party.

The filing of this remedial plan should not be interpreted as an indication of BCBSM's agreement with all of the findings in the Determination Report. There are, in fact, many finding with which we do not agree. The most troubling findings, and our concerns about them, will be outlined in a separate letter to you.

If you have any question about this filing, please contact me.

Sincerely,

Lisa M. Varnier
Assistant General Counsel
Regulatory Affairs.

Attachment

LMV/jd

If you have any question about this filing, please contact me.

Sincerely,

Lisa M. Varnier
Assistant General Counsel
Regulatory Affairs.

Attachment

LMV/jd

bcc: R. Kasperek S. Victor G. Steinhauer
K. Seitz E. Ward

Blue Cross
Blue Shield
of Michigan

Ambulatory Surgery Facilities Provider Class Plan

DECEMBER 29, 2000

PROVIDER CLASS

A provider class may include health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members. Qualification standards and the scope of services for which reimbursement will be made may differ for the types of providers within a provider class.

Definition

An ambulatory surgery facility under this provider class plan is a Michigan licensed facility that provides surgery and related care that can be performed without requiring inpatient hospital care. An ambulatory surgery facility excludes the office of a physician or other private practice office.

Scope of Services

Ambulatory surgery facility providers can perform surgeries pertaining to the following systems:

- Integumentary
- Respiratory
- Digestive
- Male genital
- Nervous
- Auditory
- Musculoskeletal
- Cardiovascular
- Urinary
- Female genital
- Eye/ocular addenda

P.A. 350 GOALS AND OBJECTIVES

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\frac{(100 + I) \ * (100 + REG)}{100} \qquad 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made."

Objectives

- Limit the rate of increase in total payments per member for ambulatory surgery facility providers to the compound rate of inflation and real economic growth, as specified in P.A. 350, giving consideration to Michigan and national health care market conditions.
- Provide equitable reimbursement to ambulatory surgery facility providers in return for high quality services that are medically necessary.

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Objectives

- Participate with all ambulatory surgery facilities that meet BCBSM's qualification standards.
- Move toward an increased participation rate by restructuring the qualification standards for participation.
- Minimize disruptions in patient care and physician surgical practices by allowing providers a transition period for meeting Evidence of Necessity standards. Advise the Insurance Commissioner of the progress of each step of the transition period and implementation process.
- Recognize the unique needs of rural areas by establishing specific operating room minimums for rural ambulatory surgery facilities.
- Provide members with current addresses and telephone numbers of all participating ambulatory surgery facility providers.
- Review reimbursement levels periodically and adjust as necessary.

Quality Of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Objectives

- Apply and monitor providers' compliance with participation requirements and performance standards.
- Assess member satisfaction with ambulatory surgery facility services.

- Meet with the ambulatory surgery facilities liaison committee at least two times annually to allow providers the opportunity to discuss with BCBSM such issues as quality of care, medical necessity, administrative concerns, participation standards, etc.

- Regularly provide all participating providers with information on topics such as changes in payable services, group benefit changes, billing requirements, in addition to general educational materials.

- Maintain and update, as necessary, an appeals process that allows providers to appeal individual claims disputes or utilization review audits. This process is described in Addendum C of the Ambulatory Surgical Facility Participation Agreement.

BCBSM POLICIES & PROGRAMS

BCBSM maintains a comprehensive set of policies and programs that work toward achieving the provider class plan goals and objectives. These policies and programs are designed to help BCBSM meet the P.A. 350 goals by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the P.A. 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

BCBSM may issue a participating contract that covers all members of a provider class or it may offer a separate and individual contract on a per claim basis, if applicable to the provider class.

Participation Policy

Participation for ambulatory surgery facilities is on a formal basis only. Facility services rendered in a non-participating ambulatory surgery facility are not reimbursed. In order to participate, providers must meet all of BCBSM's qualification standards.

Qualification Standards

To qualify as a participating ambulatory surgery facility, providers must meet and continue to meet the following requirements:

- Have a physical structure other than the office of a physician, dentist, podiatrist or other private practice office, offering surgical procedures and related services that can be performed without requiring inpatient hospital care.
- Be licensed by the state of Michigan as a Freestanding Surgical Outpatient Facility (FSOF), and meet any requirements of applicable federal law.
- Be accredited as an ambulatory health care provider by at least one national accreditation organization such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or the Accreditation Association for Ambulatory Health Care (AAAHC), or any additional accreditation organization approved by BCBSM.
- Be Medicare certified as an Ambulatory Surgery Center (ASC), or determined by Medicare to be an extension or part of a Medicare certified hospital.

- Provide surgery within at least two of the following body systems for designation as a multi-specialty ASF: integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/ocular adnexa and auditory, etc.

- Provide surgery within only one body system for designation as a single-specialty ASF: integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/ocular adnexa, auditory, etc.

- Maintain a minimum of three Michigan Department of Community Health (MDCH) designated operating rooms for non-rural multi-specialty ASFs, and a minimum of two MDCH designated operating rooms for non-rural single-specialty ASFs. Non-rural is determined by the United State's Department of Agriculture's most recent Rural-Urban Continuum Code. Facilities that have more than the minimum number of operating rooms must still meet all volume requirements described under the Evidence of Necessity standard.

- Maintain a minimum of two MDCH designated operating rooms for rural multi-specialty ASFs and a minimum of one MDCH designated operating room for rural single-specialty ASFs. Rural is determined by the United State's Department of Agriculture's most recent Rural-Urban Continuum Code. Facilities that have more than the minimum number of operating rooms must still meet all volume requirements described under the Evidence of Necessity standard.

- Patients admitted to the ambulatory surgery facility must be under the care of a licensed physician. A physician should be available on-site at all times when a patient is on the facility's premises. The ambulatory surgery facility should make provisions for patient care services which are appropriate to the needs of the patients and the community it serves.

- Have an organized medical staff, established in accordance with policies and procedures developed by the facility, that is responsible for maintaining proper standards of medical care. Membership on the medical staff must be available to qualified physicians in the community. Criteria for membership on the medical staff will be established and enforced by a credentials evaluation program established by the facility.

- Have a written agreement with at least one acute care general hospital, within a reasonable travel time, as determined by BCBSM, to facilitate prompt transfer of patients requiring hospital care. The written agreement with a hospital shall provide that copies of the facility's medical records shall be transmitted to the hospital where the patient is transferred.

- Conduct program evaluation, utilization review and peer review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components applicable to all patient services in accordance with the requirements of BCBSM and the appropriate accrediting and regulatory agencies.

- Have a governing board that is legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment.

- Financial affairs must be conducted in a manner consistent with prudent fiscal management. Records of its transactions shall be maintained in conformity with generally accepted accounting principles, and with BCBSM billing, reporting and reimbursement policies and procedures.

- Meet the Evidence of Necessity minimum volume requirements at the time of initial application and annually thereafter.

Evidence of Necessity Transition Period

Beginning with this plan's implementation, and ending October 1, 2001, there will be a transition period to minimize disruptions in the delivery of surgical services. During this period, providers may either apply or participate under specific conditions.

Volume reports must have a signed attestation from the facility owners or officers regarding their accuracy. The reports must clearly identify the type of room in which cases were performed (i.e. a licensed operating room on a sterile corridor, a dedicated endoscopy/cystoscopy room, or some other non-operating room). Procedures performed in a room not designated as an operating room on the corresponding Michigan Department of Community Health's Annual Hospital Statistical Survey will not be counted as part of the facility's overall volume.

The following Evidence of Necessity conditions will apply during the transition period for participating and nonparticipating applicant ambulatory surgery facilities:

- **Participating Facilities**

Providers that currently participate with BCBSM will be allowed a period of time to meet the new volume requirements. These providers will have 60 days from the implementation of this provider class plan to submit to BCBSM their surgical case or hour volume attestations for calendar year 2000. Facilities that participated for the full year must submit the full calendar year of data. Facilities that participated for less than the full year must submit volume data for all full months of participation. The data will be annualized to determine whether it meets the required minimums for participating facilities. Participating providers who have not submitted the necessary applications or volume attestations within 60 days of the plan's implementation will be given 60 days notice of termination.

Facilities that meet the minimum requirements of 1200 surgical cases or 1600 hours per operating room per year[⊕] during calendar year 2000, as well as all other participation requirements, will maintain their participation status.

Facilities with calendar year 2000 volumes within 90 percent of the required minimum that meet all other qualification standards will be granted a one-time participation grace period through the next recertification period. If the facility fails to meet the full volume requirement by the next recertification period, its participation agreement will be terminated with 60 days notice.

[⊕] BCBSM's definition of a "surgical case" and "hours of use" will be the same as that used by the Michigan Department of Community Health. The MDCH currently defines a case as a single visit to an operating room during which one or more surgical proceduresare performed. "Hours of use" is defined as the actual time an operating room is used to provide surgical services and excludes set-up and clean-up time.

Facilities with volumes between 75 and 90 percent of the required minimums that meet BCBSM's other qualification standards will be allowed a participation extension through September 30, 2001. Facilities participating during this period must submit their most recent six-months volume attestations to BCBSM by October 1, 2001. If these facilities meet the 1200 surgical cases or 1600 hours requirement (based upon their most recent six months volume annualized), and BCBSM's other qualification standards, they will be allowed to maintain their participation status. Facilities that do not meet the full volume requirements or any other qualification standards will be notified by December 1, 2001 that their participation agreements will be terminated with 60 days notice.

Participating facilities with calendar year 2000 volumes that are less than 75 percent of the required minimum volume (i.e., less than 900 cases or 1200 hours per operating room per year), are not eligible to participate. Providers will be notified within 60 days of receiving their completed applications and volumes that their participation will be terminated with 60 days notice. Similarly, facilities that do not meet all other participation requirements, such as the minimum operating room requirement, will have their participation agreement terminated with 60 days notice.

A participating provider who intends to delicense one or more operating rooms to meet the volume requirements must notify BCBSM of this intent at the time of its initial application and volume submission (i.e. within 60 days of the remedial plan's implementation). BCBSM will conditionally approve a provider for participation if: (1) the provider notifies BCBSM of its intent to delicense an operating room at the time of its application; (2) the provider meets all qualification standards except the volume requirements at the time of application; (3) the provider indicates that it will delicense one or more operating rooms in order to meet the minimum volume; and (4) the delicensing of rooms will result in the provider meeting the volume requirements.

The provider must submit documentation within 60 days of BCBSM's conditional approval that a room has been delicensed. The facility must continue to meet EON and all other qualification standards in order to participate. If these requirements are not met, the conditional approval will expire and the provider's agreement will be terminated with 60 days notice.

- **Nonparticipating Facilities**

During this transition period, non-participating facilities will be allowed to submit their most recent six months volume annualized. The minimum volume a facility must meet in each calendar year is 1200 surgical cases or 1600 hours per operating room per year. This standard will be adjusted for non-participating facilities to reflect that the facility has not had access to BCBSM's market share. The adjustment will be the greater of 25 percent of the minimum volume requirements for cases or hours, or BCBSM's market share within the state defined Health Service Area (HSA) in which the facility is located. BCBSM market share is determined by comparing overall outpatient charges in the HSA to BCBSM outpatient charges, using the most recent available data.

Facilities that provided services to BCBSM members during the period for which they are submitting volume information may not include those cases where BCBSM is the primary payor if they wish to qualify for the market share adjustment. If the patient has another carrier or has Medicare as the primary insurer, the case may be included in the volume total even if BCBSM is the secondary or supplemental insurer.

Within 60 days of receiving the provider's application and volume report, BCBSM will send a letter to the provider indicating their eligibility for participation status. Providers who don't meet the EON requirements will have their applications suspended with a letter explaining why the application was suspended.

A nonparticipating provider who intends to delicense one or more operating rooms to meet the volume requirements will notify BCBSM of this intent at the time of its initial application and volume submission (i.e. within 60 days of the remedial plan's implementation). BCBSM will conditionally approve a provider for participation if: (1) the provider notifies BCBSM of its intent to delicense an operating room at the time of its application; (2) the provider meets all qualification standards except the volume requirements at the time of application; (3) the provider indicates that it will delicense one or more operating rooms in order to meet the minimum volume; and (4) the delicensing of rooms will result in the provider meeting the volume requirements.

The provider must submit documentation to BCBSM within 60 days of BCBSM's conditional approval that a room has been delicensed. The facility must continue to meet all other qualification standards. If these requirements are not met, the conditional approval will expire and the provider will not be granted a participation agreement.

Evidence of Necessity Implementation

Effective January 1, 2002 and thereafter, all volume attestations from participating ambulatory surgery facilities must be submitted to BCBSM by March 1 of each year. Nonparticipating providers may submit applications and volume attestations at any time.

Volume reports must have a signed attestation from the facility owners or officers regarding their accuracy. The reports must clearly identify the type of room in which cases were performed (i.e. a licensed operating room on a sterile corridor, a dedicated endoscopy/cystoscopy room, or some other non-operating room). Procedures performed in a room not designated as an operating room on the corresponding Michigan Department of Community Health's Annual Hospital Statistical Survey will not be counted as part of the facility's overall volume.

The following Evidence of Necessity criteria for participating and nonparticipating ambulatory surgery facilities will be applied:

- **Participating Facilities**

Participating facilities must maintain a standard of at least 1200 surgical cases or 1600 hours per operating room per calendar year. Facilities that participated for a full year must submit the full calendar year of data. Facilities that participated for less than a full calendar year must submit volume data for all full months of participation. The data will then be annualized.

Participating facilities that are within 90 percent of the minimum volume requirements will be given a one-time grace period. If the facility fails to meet the full volume requirements by the next recertification period, its participation agreement will be terminated with 60 days notice. A participating facility that falls below 90 percent of the minimum volume requirement will not be granted a grace period. Instead, its participation agreement will be terminated with 60 days notice. All termination notices will be sent to providers by May 1 of each year.

A participating provider who intends to delicense one or more operating rooms to meet the volume requirements must notify BCBSM of this intent. BCBSM will conditionally approve a provider for participation if: (1) the provider notifies BCBSM of its intent to delicense an operating room at the time of its application; (2) the provider meets all qualification standards except the volume requirements at the time of application; (3) the provider indicates that it will delicense one or more operating rooms in order to meet the minimum volume; and (4) the delicensing of rooms will result in the provider meeting the volume requirement.

The provider must submit documentation within 60 days of BCBSM's conditional approval that a room has been delicensed. The facility must also continue to meet EON and all other qualification standards in order for the provider to maintain its participation status. If the above requirements are not met, the provider's participation agreement will be terminated with 60 days notice.

- **Nonparticipating Facilities**

The minimum volume a facility must meet in each calendar year is 1200 surgical cases or 1600 hours per operating room per year. This standard will be adjusted for non-participating facilities to reflect that the facility has not had access to BCBSM's market share. The adjustment will be the greater of 25 percent of the minimum volume requirements or BCBSM's market share within the state defined Health Service Area (HSA) in which the facility is located. BCBSM market share is determined by comparing overall outpatient charges in the (HSA) to BCBSM outpatient charges, using the most recent available data.

Facilities that provided services to BCBSM members during the period for which they are submitting volume information may not include those cases where BCBSM is the primary payor if they wish to qualify for the BCBSM market share adjustment. If the patient has another carrier or has Medicare as the primary insurer, the case may be included in the volume total even if BCBSM is the secondary or supplemental insurer.

New facilities that have been operational for more than one year will be required to submit the full calendar year of data. Applicant facilities that have been operational for one year or less will be allowed to submit their most recent six months volume annualized.

A nonparticipating provider who intends to delicense one or more operating rooms to meet the volume requirements must notify BCBSM of this intent. BCBSM will conditionally approve a provider for participation if: (1) the provider notifies BCBSM of its intent to delicense an operating room at the time of its application; (2) the provider meets all qualification standards except the volume requirements at the time of its application; (3) the provider indicates that it will delicense one or more operating rooms in order to meet the minimum volume; and (4) the delicensing of rooms will result in the provider meeting the volume requirement.

The provider must submit documentation within 60 days of BCBSM's conditional approval that a room has been delicensed. The facility must also continue to meet EON and all other qualification standards in order for the provider to participate with BCBSM. If the above requirements are not met, the provider will not be granted a participation agreement.

BCBSM will notify facilities of their participation status within 60 days of receiving their completed applications and volume reports. Providers found to be ineligible for participation for any reason will have review of their applications suspended. A letter will be sent to the provider within 60 days of receiving the application stating the reasons for the suspension.

- **Operating Room Exchanges**

  The trading of operating rooms for Evidence of Necessity purposes, in which a hospital closes one or more of its operating rooms in exchange for approval of an ambulatory surgery facility operating room, will not be allowed.

Termination of Contract

Participation may be terminated by BCBSM with 60 days notice if an ambulatory surgery facility fails to meet minimum volume standards. A designated single-specialty facility that submits claims for services outside of its designated specialty will have its participation agreement terminated with 60 days notice. An ASF that fails to meet any other qualification standard established by BCBSM, and described in Addendum A of the Ambulatory Surgery Facility Participation Agreement, will have its participation agreement terminated with 60 days notice. Any facility found to knowingly submit false volume information will have its participation agreement immediately terminated.

Termination of the participating agreement may also occur by either BCBSM or the provider under the terms and conditions specified in Article V of the Ambulatory Surgery Facilities Participation Agreement.

Provider Programs

BCBSM strives to ensure the appropriateness and quality of the services delivered to subscribers through a combination of communication, education, and quality assurance programs that oversee and support health care providers.

Utilization Management Initiatives

BCBSM requires that ambulatory surgery facilities develop and implement their own program evaluation, utilization management and peer review programs. These programs must:

- Assess the quality of care provided to patients to ensure that proper services are provided at the proper time by qualified individuals
- Identify, refer, report and follow up on quality of care issues and problems
- Monitor all aspects of patient care delivery

The utilization management and peer review plan must be written and must identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan including:

- Quality, content and completeness of the medical records
- Clinical performance
- Quality and appropriateness of diagnostic and treatment procedures
- Evaluation of tissue specimens
- Medication utilization
- Patient satisfaction
- Quality and appropriateness of anesthesia
- Arrangements for patients requiring hospitalization following ambulatory surgery

Education/Communications

- Participating ambulatory surgery facilities routinely receive the *Hospital & Facility News.*
- BCBSM's regional field services representatives visit ambulatory surgery facilities on-site for individualized provider education, and provide on-going assistance to facility staff.
- BCBSM meets twice annually with the ambulatory surgery facility liaison committee.
- BCBSM maintains and updates as necessary, the *Guide for Participating Ambulatory Surgery Facilities.*
- Provider participation information is available on the BCBSM corporate web page or the Provider Inquiry and Customer Service Inquiry toll-free hotlines.

Performance Monitoring

- Ambulatory surgery facilities are annually recertified to ensure compliance with Evidence of Necessity standards. Applications and volume attestations are submitted by March 1 of each year.

- Ambulatory surgery facilities are periodically surveyed to ensure they maintain up-to-date compliance with licensing requirements and all other qualification standards.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Utilization review audits, when conducted, work to ensure that providers rendered services appropriately and within the scope of members' benefits.
- BCBSM will develop a satisfaction survey to assess member perceptions of the care provided at participating ambulatory surgery facilities.

Reimbursement Policies

BCBSM reimburses participating ambulatory surgical facilities for covered services deemed medically necessary by BCBSM. Determination of medical necessity is described in the attached Ambulatory Surgery Facility Participation Agreement.

Covered Services

Reimbursement for covered services provided in an ambulatory surgery facility covers services directly related to the surgical procedure, including the following items:

- Use of the ambulatory surgery facility including operating, recovery, or other treatment rooms, pre-operative areas, patient preparation areas, post-operative areas used by the patient or offered for use to the patient's relatives in connection with surgical procedures
- Nursing and technical services
- EKGs
- Drugs, biological, surgical dressings, supplies, splints, casts, implant prosthetics, and equipment directly related to the provision of the surgical procedure
- Materials for anesthesia
- Routine laboratory services performed on the day of the surgery, radiology services performed with equipment owned or operated by the facility
- Administrative, record keeping and housekeeping items and services

Reimbursement Methods

Payment for outpatient surgical procedures is based on one of the following three reimbursement methods:

- Price-based payment for ambulatory surgical procedures which are not commonly performed in physicians' offices, as determined by BCBSM, is based on a conversion of billed charges to costs, and a BCBSM determined surgical pricing formula.
- Statewide percentage of charges payment for procedures which are not commonly performed in physicians' offices, as determined by BCBSM, and for which BCBSM has insufficient utilization

data to establish a reasonable price, is based on the approved charge multiplied by the statewide percentage of charges as determined by BCBSM.

- Nominal price-based payment for surgical procedures predominantly performed in physicians' offices, as determined by BCBSM, is based on 50 percent of the physician practice expense of the BCBSM physician fee for each procedure.

Payment for laboratory and radiology procedures is a price-based system using the technical component of the BCBSM physician fee for each procedure.

Payment for EKGs are based on a statewide percentage of charge payments.

Hold Harmless Provisions

Participating ambulatory surgery facilities agree to accept BCBSM's payment as payment in full. Member copayments and/or deductibles are subtracted from BCBSM's payment before the facility is reimbursed. Participating providers hold members harmless from:

- Balance billing, unless the services rendered are not covered services
- Medically unnecessary services, as determined by BCBSM, unless the member acknowledges that BCBSM will not pay for the services and agrees in writing before the services are rendered to assume liability
- Financial obligation for covered services provided but not billed to BCBSM within 12 months under the circumstances specified in the Ambulatory Surgery Facility Participation Agreement

Appeals Process

Participating providers have the right to appeal BCBSM decisions regarding individual claims disputes and utilization review audit determinations. The complete process is described in Addendum C of the Ambulatory Surgery Facility Participation Agreement.

AMBULATORY SURGERY FACILITIES PARTICIPATION AGREEMENT (Attached)

DRAFT 12-29-00

BLUE CROSS BLUE SHIELD OF MICHIGAN
AMBULATORY SURGERY FACILITY
PARTICIPATION AGREEMENT

This Agreement is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and _____, (Facility), an Ambulatory Surgery Facility, whose address is _____.

ARTICLE I
DEFINITIONS

1.1 "**Agreement**" means this Agreement, all exhibits, and addenda attached hereto, or other documents expressly incorporated herein.

1.2 "**Ambulatory Surgery Facility**" **or** "**ASF**" means a facility that provides outpatient ambulatory surgery Covered Services and that meets all the Qualifications Standards stated in Addendum A.

1.3 "**Approved Site**" means the Ambulatory Surgery Facility location specifically approved and contracted by BCBSM.

1.4 "**Certificate**" means benefit plan descriptions under the sponsorship of BCBSM or other Blue Cross and Blue Shield (BCBS) Plans, or certificates and riders issued by or under their sponsorship, or arrangements with any employer group, including any self-funded plan, where BCBSM or other BCBS Plans administer benefits; and, unless the subject of a separate agreement with Facility, any Preferred Provider Organizations (PPOs) or other alternative delivery system owned, controlled, administered or operated in whole or part by BCBSM, excluding BCBSM's subsidiaries, or by other BCBS Plans.

1.5 "**Covered Services**" means those ambulatory surgery facility services that are (i) listed or provided for in Certificates, and (ii) provided at an Approved Site.

1.6 "**Medically Necessary**" means a determination by Physicians acting for BCBSM that a Covered Service meets all of the following conditions: (i) it is rendered for the treatment, diagnosis or symptoms of an injury, condition or disease; (ii) the care, treatment or supply is appropriate given the symptoms, and is consistent with the diagnosis, "Appropriate" means that the type, level, and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment; (iii) it is not mainly for the convenience of the Member or of the Member's health care provider; (iv) it is not treatment that is generally regarded as experimental or investigational by BCBSM; and (v) it is not determined to be medically inappropriate.

1.7 "**Member**" means a person entitled to receive Covered Services pursuant to Certificates.

1.8 "**Noncovered Services**" means those services that are not Covered Services.

1.9 "**Qualification Standards**" means those criteria established by BCBSM that are used to determine Facility's eligibility to become or remain a participating Ambulatory Surgery Facility as set forth Addendum A.

1.10 "**Physician**", for the limited purposes of this Agreement, means a medical doctor (MD), a doctor of osteopathy (DO), or doctor of podiatry (DPM), licensed in Michigan.

1.11 "**Reimbursement Methodology**" means the methodology by which BCBSM determines the amount of payment due Facility for Covered Services as set forth in Addendum B.

ARTICLE II
FACILITY RESPONSIBILITIES

2.1 **Services to Members.** Facility, within the limitations of its licensed scope of services, will provide Covered Services to Members based on requirements in Members' Certificates and as governed by the terms and conditions of this Agreement and all other BCBSM policies in effect on the date Covered Services are provided.

2.2 **Qualification Standards.** Facility will comply with the Qualification Standards established by BCBSM and further agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without 60 days prior written notice to Facility. Upon request, Facility will submit to BCBSM evidence of continuing compliance with all Qualification Standards. Notice of changes to Qualification Standards may be given as stated in Section 5.12, or, at BCBSM's option, by publication in the appropriate BCBSM provider publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility. The current Qualification Standards are set forth in Addendum A.

2.3 **Listing of Facilities.** Facility agrees that BCBSM shall have the right to include Facility's name, address and location in listings or other written documents provided for assisting Members to obtain Covered Services from a participating Ambulatory Surgery Facility.

2.4 **Claims Submission.** Facility will submit acceptable claims for Covered Services directly to BCBSM using BCBSM approved claim forms, direct data entry systems, tape-to-tape systems or such other methods as BCBSM may approve from time to time. An "acceptable claim" is one that complies with the requirements as stated in appropriately published BCBSM administrative manuals or additional published guidelines or criteria.

Acceptable claims for Covered Services shall be submitted within 12 months of the date of service. Claims submitted more than 12 months following the date of service, shall not be entitled to reimbursement except as set forth in Addendum F. Facility will endeavor to file complete and accurate claims and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum E.

2.5 **BCBSM Payment.** Facility will only look to BCBSM for reimbursement for Covered Services and will request reimbursement from Members only for applicable deductibles and copayments for Covered Services, or for services it furnishes that are not Covered Services. Facility agrees not to collect any further payment, except as provided in Addendum F. Facility may not request or require Members to sign an agreement or form to reimburse Facility for any charges in excess of BCBSM's reimbursement for Covered Services, unless otherwise stated in this Agreement. Facility may not collect deposits from Members for Covered Services. Facility may not waive copayments and/or deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member's record or where reasonable efforts to collect have failed.

2.6 **Utilization and Quality Programs.** Facility will adhere to BCBSM's published policies, procedures, and requirements regarding utilization review, quality assessment, quality improvement, patient satisfaction surveys, preauthorization, case management, disease management, or other programs established or modified by BCBSM. BCBSM agrees to furnish Facility with information necessary to adhere to such programs, policies and procedures.

2.7 **BCBSM Access to Records.** BCBSM represents that Members, by contract, as a condition precedent to receiving benefits, agree to the release of information and records to BCBSM from Facility and Physicians, including but not limited to, all medical and other information relating to their care and treatment. Facility shall obtain any further releases or waivers it believes are necessary for the purpose of providing to BCBSM Member medical and billing records related to Covered Services. Facility will release patient information and records within 30 days of BCBSM's request to enable BCBSM to process claims, to verify compliance with BCBSM's Qualification Standards, and for prepayment or postpayment review of medical records that relate to filed claims.

2.8 **Confidentiality.** Facility will maintain the confidentiality of the medical records and related information of Members as required in this Agreement and in accordance with applicable state and federal law.

2.9 **Approved Site.** Facility's Approved Site must be specifically approved by BCBSM. Facility's Approved Site is listed in the Signature Document to this Agreement.

2.10 **Records and Record Retention.** Facility will prepare and maintain all appropriate medical and financial records related to Covered Services provided to Members as required by BCBSM published policies and procedures and as required by law.

2.11 **Audits and Recovery.** Subject to all applicable laws and the confidentiality provisions set forth in this Agreement, Facility agrees that:

a.) Medical Record and Billing Reviews. BCBSM may photocopy, review and audit Facility's records to determine program compliance. Such audits include, but are not limited to, verification of services provided, adherence to BCBSM's published policies, Medical Necessity of services provided, and appropriateness of revenue/procedure codes reported to BCBSM. BCBSM is entitled to obtain recoveries based on such audits as set forth in Addendum G.

b.) Financial Audits. Facility will allow BCBSM to conduct reasonable audits of Facility's financial records. Facility will provide BCBSM with on-site access during Facility's regular business hours to financial records as may be necessary for validating Facility's compliance with Qualification Standards, or for establishing or validating appropriate reimbursement under this Agreement.

2.12 **Facility Changes.** Facility will notify BCBSM, in writing, at least 30 days prior to implementation of major changes, such as, but not limited to, changes in: (i) name; (ii) location; or (iii) ownership. Facility will also notify BCBSM within five business days of Facility's knowledge of any material changes in Facility's professional and administrative staffing; reduction or expansion of surgical services provided if relevant to BCBSM's determination of Facility's categorization as a single-specialty or multi-specialty ASF as described in Addendum A; any reduction or expansion of the number of Facility's operating rooms; licensure; accreditation; or, Medicare certification. Such prior notification of changes is required so that BCBSM may determine Facility's continued compliance with Qualification Standards and contractual obligations. Prior notification of

major program or administrative changes, such as changes in location and ownership, does not ensure continued Facility approval by BCBSM. Ownership and location changes, as well as other major changes, require specific BCBSM approval for continued participation by Facility.

Facility will also notify BCBSM of any actions, policies, determinations, or internal or external developments that may have a direct impact on the provision of Covered Services to Members. Such notification includes, but is not limited to, any legal or government action initiated against the Facility, or any of its owners, officers, directors or employees that affects this Agreement, including but not limited to any action for professional negligence, fraud, violation of any law, or against any health care license.

2.13 **Successor's Obligations.** Facility will require any prospective successor to its interest to assume liability for any amounts for which Facility is indebted to BCBSM, whether evidenced by a promissory note or otherwise. Such assumption of liability shall be one of the conditions for BCBSM approval of any successor in interest as a participating Facility. Such assumption of liability shall not release Facility from the indebtedness unless an agreement to that effect is entered into between BCBSM, the Facility, and any prospective successor, or the successor is a participating Facility and expressly agrees to assume Facility's liabilities to BCBSM.

2.14 **State and Federal Laws.** Facility will provide Covered Services in a manner which conforms to (i) all applicable federal, state and local laws, rules and regulations, and (ii) the standards of professional conduct and practice prevailing in the applicable community during this Agreement.

2.15 **Subcontracting.** Facility must have a written contract with all subcontracted staff. Facility is responsible for ensuring that the subcontracted staff (i) is qualified to perform the service they are subcontracted to perform, (ii) meets and maintains any relevant Qualification Standards, and (iii) adheres to BCBSM's published policies and procedures. Facility remains responsible for the acts or omissions of its subcontracted staff. Facility will furnish a copy of such subcontract to BCBSM upon request.

2.16 **Approved Site.** Facility's Approved Site is listed in the Signature Document.

2.17 **Transfer of Services by BCBSM.** Facility understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services, and may conduct business through representatives and agents. Facility agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

ARTICLE III
BCBSM RESPONSIBILITIES

3.1 **General.** BCBSM's payment obligations pursuant to this Agreement will be limited to Covered Services provided by Facility in accordance with the terms and conditions contained herein.

3.2 **Member Identification.** BCBSM shall provide Members with identification cards and with written information necessary to inform Members of the procedures for obtaining Covered Services from Facility and of their obligations for copayments, deductibles and Noncovered Services.

3.3 **Eligibility and Benefit Verification.** BCBSM will provide Facility with a system and/or method to promptly verify eligibility and benefit coverages of Members; provided that any such verification by BCBSM will be given as a service and not as a guarantee of payment.

3.4 **Claims Processing.** BCBSM will process claims submitted by Facility for Covered Services provided to Members in a timely fashion and in accordance with the terms and conditions contained in this Agreement.

3.5 **BCBSM Reimbursement.** Pursuant to the terms and conditions contained in this Agreement, BCBSM will make direct payment to Facility for Covered Services provided to Members according to the Reimbursement Methodology set forth in Addendum B and as in effect on the dates Covered Services are provided. Reimbursement under this Agreement will not include any amount for professional services but will be limited to facility services, nor will reimbursement include any amounts not properly payable under any coordination of benefits provisions or where another party is liable, in which case BCBSM payment will be the amount BCBSM would have normally paid for such Covered Services less any amount received by Facility from another party.

3.6 **Administrative Manuals and Bulletins.** BCBSM will provide, at no charge to Facility, one copy of administrative manuals, bulletins and such other information and documentation as shall be necessary for Facility to properly provide and be reimbursed for Covered Services provided to Members pursuant to this Agreement.

3.7 **Audits and Recovery.** Audits will be conducted and recoveries obtained in accordance with Section 2.11 and Addendum G of this Agreement.

3.8 **Appeal Processes.** BCBSM will provide an appeal process for Facility in accordance with Addendum C, if Facility disagrees with any claim adjudication or utilization review audit determination.

3.9 **Confidentiality.** BCBSM shall maintain the confidentiality of Members' records and Facility financial information of a confidential or sensitive nature in accordance with BCBSM's Confidentiality Policy in Addendum D. BCBSM will indemnify and hold Facility harmless from any claims or litigation brought by Members asserting any breach of such Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding Facility information and data, or from communicating with customers regarding aggregate data pertaining to Facility and participating Ambulatory Surgery Facilities.

ARTICLE IV
FACILITY ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

4.1 This contract is between Facility and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, Facility agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to Facility under this Agreement and no other obligations are created or implied by this language.

ARTICLE V
GENERAL PROVISIONS

5.1 **Term.** The term of this Agreement shall begin on the effective date indicated on the Signature Document and shall continue until terminated as provided herein below.

5.2 **Termination.** This Agreement may be terminated as follows:

a. by either party, with or without cause, upon 60 days written notice to the other party;

b. by either party, immediately, where there is a material breach of this Agreement by Facility that is not cured within 30 business days of written notice to the other party;

c. by BCBSM, automatically and without notice, if Facility has its license or accreditation suspended, revoked, or nullified or if Facility or an officer, director, owner or principal of the Facility is convicted of or pleads to a felony or other violation of law;

d. by BCBSM, with 60 days notice, except as otherwise stated in Article V. Section 5.2c, if Facility fails to meet the Qualification Standards set forth in Addendum A.

e. by BCBSM, immediately, if Facility knowingly submits false volume data for the purposes of BCBSM's Evidence of Necessity determination;

f by either party, upon the filing of any involuntary or voluntary proceeding in bankruptcy against either party, insolvency of any party, upon the appointment of a receiver of any party, or any other similar proceeding if such proceedings are not dismissed or withdrawn within 60 days;

g. by either party, immediately, if Facility ceases providing ambulatory surgery services, ceases providing ambulatory surgery services to Members, or ceases doing business;

h. by BCBSM, immediately, at its option, if there is a change in the ownership of Facility; or

i by BCBSM if termination of this Agreement is ordered by the State Insurance Commissioner.

5.3 **Existing Obligations.** Termination of this Agreement shall not in any way affect the obligations of the Parties under this Agreement prior to the date of termination. Such obligations shall include, but are not limited to, completion of all medical records and cooperation with BCBSM with respect to any actions arising out of relationships created by this Agreement filed against BCBSM after the effective date of termination. This Agreement shall remain in effect for the resolution of all matters pending on the date of termination. Upon termination of this Agreement, BCBSM's obligation to reimburse Facility for any Covered Services will be limited to those provided through the date of termination.

5.4 **Right of Recovery.** The expiration or termination of this Agreement or any changes as provided in this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from Facility for overpayments or for recoveries based upon any audit

conducted pursuant to the terms of this Agreement. Such rights of BCBSM shall survive the termination of this Agreement.

5.5 **Nondiscrimination.** Facility will not discriminate because of age, sex, race, religion, color, marital status, residence, lawful occupation or national origin, in any area of Facility's operations, including but not limited to employment, patient registration and care, and clinical staff training and selection. Any violation of this provision by Facility shall constitute a material breach and give BCBSM the right to immediately terminate this Agreement as provided in Article V. Section 5.2b. of this Agreement.

5.6 **Relationship of Parties.** BCBSM and Facility are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement.

5.7 **Assignment.** Any assignment of this Agreement by either party without the prior written consent of the other party will be null and void, except as stated in Article II. Section 2.17 of this Agreement.

5.8 **Amendment.** This Agreement may be altered, amended, or modified at any time by the prior written consent of the parties, provided however, that BCBSM shall have the right to unilaterally amend this Agreement upon giving 90 days prior written notice to Facility, or such lesser advance notice as may be otherwise provided in this Agreement. Notice shall be given as provided in Article V. Section 5.12 of this Agreement, or, at BCBSM's option, by publication in the appropriate BCBSM provider publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility.

5.9 **Waiver.** No waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by the appropriate representatives of BCBSM or the Facility, against whom such a waiver is being sought. Any waiver of one or more of the provisions of this Agreement or failure to enforce the Agreement by either of the parties hereto shall not be construed as a waiver of any subsequent breach of the Agreement or any of its provisions.

5.10 **Scope and Effect.** This Agreement along with any attachments shall supersede any and all present or prior agreements and understandings between the parties regarding the subject matter hereof, whether written or oral, shall constitute the entire agreement and understanding between the parties and be binding upon their respective successors and assignees.

5.11 **Severability.** If any provision of the Agreement is deemed or rendered invalid or unenforceable by any state or federal law, rule, regulation or decision of any court of competent jurisdiction, the remaining provisions of the Agreement shall remain in full force and effect; provided, however, should any such invalidity or unenforceability and its removal has the effect of materially changing the obligations of either party, as in the judgment of the party affected, (i) will cause it serious financial hardship, or (ii) cause it to be in violation of its corporate Articles of Incorporation or Bylaws, such party shall have the right to terminate this Agreement upon 30 days prior written notice to the other party.

5.12 **Notices.** Any notice required or permitted under this Agreement shall be given in writing and sent to the other party by hand delivery, or postage prepaid regular mail at the following address or such other address as a party may designate from time to time.

If to BCBSM:

Provider Contracting - B776
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

If to Facility:

Address indicated on BCBSM Provider File

5.13 **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.

5.14 **Other Agreements.** BCBSM and Facility acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

5.15 **Governing Law.** This Agreement will be governed and construed according to the laws of the state of Michigan. Jurisdiction of any dispute will be Michigan.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

ADDENDA

A. Qualifications Standards

B. Reimbursement Methodology

C. Disputes and Appeals

D Confidentiality Policy

E. Service Reporting and Claims Overpayment Policy

F. Services for Which Facility May Bill Members

G. Audit and Recovery Policy

QUALIFICATION STANDARDS

To qualify as a participating BCBSM Ambulatory Surgery Facility, Facility must meet, and continue to meet the following requirements:

1. Physical Structure and Services. Facility must be a structure, other than the office of a physician, dentist, podiatrist or other private practice office, offering ambulatory surgery and related care that does not require inpatient hospital care.

2. Licensure. Facility must be licensed by the state of Michigan as a Freestanding Surgical Outpatient Facility (FSOF), and meet any requirements of applicable federal law.

3. Accreditation. Facility must be accredited under the appropriate program (i.e., ambulatory health care) by at least one national accreditation organization approved by BCBSM, such as, but not limited to:

   - Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
   - American Osteopathic Association (AOA), or
   - Accreditation Association for Ambulatory Health Care (AAAHC).

4. Medicare Certification. Facility must be certified by Medicare as an Ambulatory Surgery Center, or determined by Medicare to be an extension or part of a Medicare certified hospital.

5. Evidence of Necessity (EON). Facility meets BCBSM's Evidence of Necessity (EON) requirements at the time of initial application, and annually thereafter.

   BCBSM's EON determination will be based on each individual facility's volumes for a calendar year unless otherwise stated in this Addendum. The term "volume(s)", as used in this Agreement, refers to the number of Facility's surgical cases or hours of use, per operating room per calendar year. For BCBSM's purposes, the definition of a "surgical case" and "hours of use" will be the same as that used by the Michigan Department of Community Health (MDCH). Per the MDCH, a "surgical case" is a single visit to an operating room during which one or more surgical procedures are performed. Per the MDCH, "hours of use" means the actual time in hours, and parts thereof, an operating room is used to provide surgical services. It is the time from when a patient enters an operating room until that same patient leaves that same operating room. It excludes any pre- or post-operative room set-up or clean-up preparations, or any time a patient spends in pre- or post-operative areas including a recovery room.

   All facilities, including facilities that have more than the minimum number of required operating rooms as stated in item #10 of this Addendum, must meet the applicable volume minimums per operating room per calendar year. Facility's volumes will be determined by BCBSM via annual calendar year volume reports submitted to BCBSM by Facility. Except as otherwise stated in this Addendum, volume reports must be submitted by each March 1st with a signed attestation from Facility's owners or officers regarding its accuracy. Volume reports must clearly identify the type of room in which cases were performed. Procedures performed in a room that is not designated as an operating room on the MDCH's *Annual Hospital Statistical Survey* will not be counted as

part of Facility's overall volume. Such submitted volume reports may be audited by BCBSM, at BCBSM's option. If it is determined by BCBSM that Facility knowingly submitted false information in its volume report, Facility's participation agreement will be terminated immediately in accordance with Article V. Section 5.2e of this Agreement.

A. Except for the transition period described in Section B. below, Facility's compliance with minimum volumes will be determined as follows:

1) Participating ASFs

Participating ASFs must be recertified for EON compliance on an annual basis. Once Facility commences participation with BCBSM, Facility must demonstrate by March 1st of each year that Facility performed a minimum of 1200 surgical cases or 1600 hours, per operating room in the preceding calendar year. Facilities that participated for the full calendar year must submit the full calendar year of data. Facilities that participated for less than the full calendar year must submit volume data for all full months of participation. The data will then be annualized to determine whether such facility meets the required volumes.

If, on annual EON recertification, Facility meets all Qualification Standards *except* the volume requirement, the following will occur:

a) If Facility's volumes fall to within 90% of the minimum volume requirement (i.e., from 1080 to 1199 surgical cases, or, from 1440 to 1599 hours, per operating room per year), Facility will be granted a one-time grace period* (i.e., until the next recertification period). If such facility fails to meet the full volume requirement by this recertification period, its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

b) If Facility's volumes fall below 90% of the minimum volume requirement (i.e., less than 1080 surgical cases or 1440 hours, per operating room per year), Facility will not be granted a grace period and its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

c) If Facility notifies BCBSM of its intention to delicense one or more operating rooms by March 1st of the applicable recertification period that it will delicense one or more of its operating rooms and such delicensing will result in Facility meeting the minimum volume requirement, BCBSM will grant conditional EON approval for 60 days. For the conditional status to be removed and participation continued beyond the 60 day period, Facility must; (i) submit appropriate documentation to BCBSM that the operating room has been delicensed within 60 days of BCBSM's conditional approval, (ii) meet the volume requirement based on the remaining number of actively licensed operating rooms, and (iii) continue to meet all other Qualification Standards (including the applicable operating room minimum). If none of these requirements is met, Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

**Subject to the terms and conditions of this Agreement*

B. Transition Period

There will be a period of transition to the EON volume requirement through September 30, 2001. Participating ASFs will have 60 days from a date specified by BCBSM to

submit their calendar year 2000 volumes and attestations. During the transition period, Facility's participation status will be determined as follows:

1) If Facility meets the Qualifications Standards, including the EON volume requirement, then Facility's participation status will continue until the next recertification period*.

2) If Facility meets all BCBSM Qualification Standards *except* the EON volume requirement, the following will apply:

   a) If Facility's volumes are within 90% of the required minimum volume (i.e., from 1080 to 1199 surgical cases or from 1440 to 1599 hours, per operating room per year), Facility will be granted a one-time participation grace period and will retain its participation status through the next recertification period*. If such facility fails to meet the full volume requirement by this recertification period, its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

   b) If Facility's volumes are between 75% and 90% of the required minimum volume (i.e., between 900 and 1,080 surgical cases or between 1200 and 1440 hours, per operating room per year), Facility will be granted an extension of its participation status through September 30, 2001*. By October 1, 2001, Facility must submit its most recent six months volume to BCBSM. If those volumes, when annualized, do not meet the calendar year volume requirement, Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

   c) If Facility's volumes are less than 75% of the required minimum volume (i.e., less than 900 surgical cases or 1200 hours, per operating room per year), Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

   d) If Facility notifies BCBSM of its intention to delicense one or more operating rooms and such delicensing will result in Facility meeting the minimum EON volume requirement, BCBSM will grant conditional EON approval for 60 days. Such notification must be given to BCBSM when Facility submits its application and volume attestation (i.e., within 60 days of the due date specified by BCBSM). For the conditional status to be removed and participation continued beyond the 60 day period, Facility must: (i) submit appropriate documentation to BCBSM that the operating room has been delicensed within 60 days of BCBSM's conditional approval, (ii) meet the volume requirement based on the remaining number of actively licensed operating rooms, and (iii) continue to meet all other Qualification Standards (including the applicable operating room minimum). If none of these requirements is met, Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

3) If Facility does not meet all Qualification Standards (other than EON as stated above), Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

4) If Facility does not submit the necessary applications or volume attestations within 60 days of a date specified by BCBSM, Facility will be given 60 days notice of termination in accordance with Article V. Section 5.2a of this Agreement.

Effective January 1, 2002, and thereafter, all volume attestations must be submitted to BCBSM by March 1st of each year.

6. Patient Care. Facility's patients must be under the care of a licensed Physician. A Physician should be available on-site at all times when a patient is on Facility's premises. Facility should make provisions for patient care services that are appropriate to the needs of the patients and the community it serves.

7. Medical Staff. Facility must have an organized medical staff, established in accordance with policies and procedures developed by Facility, which shall be responsible for maintaining proper standards of medical care.

   Membership on the medical staff shall be available to qualified Physicians in the community. Criteria for membership on the medical staff will be established and enforced by a credentials evaluation program established by Facility.

8. Relationship with Hospitals. Facility must have a written agreement with at least one acute care general hospital within reasonable travel time, as determined by BCBSM, to facilitate prompt transfer of patients requiring hospital care. The written agreements with hospitals shall provide that copies of Facility's medical records shall be transmitted to the hospital to which the patient is transferred.

9. Utilization Management and Peer Review. Facility must demonstrate that it conducts program evaluation, utilization review and peer review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components applicable to all patient services in accordance with the requirements of BCBSM and the appropriate accrediting and regulatory agencies.

   The utilization management and peer review program will:

   - Assess the quality of care rendered to patients to assure that proper services are provided at the proper time by qualified individuals
   - Identify, refer, report and follow up on quality of care issues and problems, and
   - Monitor all aspects of patient care delivery.

   The utilization management and peer review plan must be written and must identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan, including:

   - Quality, content and completeness of medical records
   - Clinical performance
   - Quality and appropriateness of diagnostic and treatment procedures
   - Evaluation of tissue specimens
   - Medication utilization
   - Patient satisfaction
   - Quality and appropriateness of anesthesia, and
   - Arrangements for patients requiring hospitalization following ambulatory surgery.

10. Operating Rooms. Facility must have a minimum number of operating rooms as specified below. To qualify as an "operating room", the room must be designated as such by the MDCH in its *Annual Hospital Statistical Survey*. Rooms not designated by MDCH as an operating room (e.g., treatment rooms) will not be included in the minimum.

A facility that has more than the minimum number of operating rooms must still meet all qualification and volume requirements described under the EON requirements.

a) Multi-Specialty Facilities – Multi-specialty facilities located in non-rural counties (per the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available) must have a minimum of three (3) operating rooms. For the purposes of this Agreement "multi-specialty" means any facility that performs surgery within two or more different body systems. Examples of "body systems" are; integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/occular adnexa, auditory, etc..

b) Single-Specialty Facilities – Single-specialty facilities located in rural counties (per the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available) must have a minimum of two (2) operating rooms. For the purposes of this Agreement "single-specialty" means any facility that performs surgery within only one body system. Examples of "body systems" are; integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/occular adnexa, auditory, etc.

   An ASF that wishes to qualify as a single-specialty ASF must attest on its application that its services are limited to a specific specialty. If a single-specialty ASF submits claims to BCSM for Covered Services outside of its designated specialty, Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2a of this Agreement.

c) Rural Facilities – For facilities located in rural counties the operating room minimum is two (2) operating rooms for multi-specialty facilities, and one (1) operating room for single-specialty facilities. Rural and non-rural counties will be determined using the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available.

11. Sponsorship, Ownership and Control. Facility must have a governing board that is legally responsible for the total operation of Facility, and for ensuring that quality medical care is provided in a safe environment.

12. Financial Affairs. Facility must conduct its financial affairs in a manner consistent with prudent fiscal management. Records of its transactions shall be maintained in conformity with generally accepted accounting principles, and with BCBSM billing, reporting and reimbursement policies and procedures.

REIMBURSEMENT METHODOLOGY

For Covered Services provided under this Agreement, BCBSM will pay Facility the lesser of Facility's charge or the ASF fee that is in effect on the date of service, less any applicable Member copayments or deductibles. ASF fees will be established using the following methodologies:

1. Outpatient Surgical Procedures:

   a. "Nominal Priced-Based Payment" for procedures commonly performed in physicians' offices, as determined by BCBSM. The payment will be based on 50% of the physician practice expense of the BCBSM physician fee for each procedure.

   b. "Statewide Percentage of Charges Payment" for procedures that are *not* commonly performed in physicians' offices, as determined by BCBSM, and for which BCBSM has insufficient utilization data to establish a reasonable price. Payment will be the approved charge multiplied by the statewide percentage of charges as determined by BCBSM.

   c. "Price Based Payment" for procedures that are not commonly performed in physicians' offices, as determined by BCBSM. The Price Based Payment is based on a conversion of billed charges to costs, and a BCBSM determined surgical pricing formula.

2. Laboratory and Radiology Procedures:

   a. Payments will be price-based using the technical component of the BCBSM physician fee for each procedure.

3. Other Procedures:

   a. EKGs are reimbursed a "Statewide Percentage of Charge Payment".

BCBSM will review Ambulatory Surgery Facility reimbursement periodically to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Notice of revisions to the ASF fees will be provided by BCBSM in advance of the effective date of the revisions. BCBSM will give Facility not less than 60 days prior notice of any material change to the Reimbursement Methodology used for establishing ASF fees.

Any required notice of reimbursement changes may, at BCBSM's option, be published in the appropriate BCBSM publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility.

ADDENDUM C

APPEALS PROCESS
FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Facility must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW

Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, Facility shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For individual claims disputes:

Provider Appeals Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For disputes regarding utilization review audit results:

Manager, Facility Utilization Review
Mail Code J 105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

--- Area of dispute;
--- Reason for disagreement;
--- Any additional supportive documentation; and
--- Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of Facility's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If Facility is dissatisfied with the determination of the Written Complaint/ Reconsideration Review, Facility may submit a written request for a Managerial-Level Review Conference (Conference). The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. Facility or Facility's representative will normally be in attendance to present their case. The Conference can be held by telephone if Facility prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

For Conferences regarding utilization review audit results disputes:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

A request for a Managerial-Level Review Conference must include the following:

--- Area of dispute;
--- Reason for disagreement;
--- Any additional supportive documentation; and
--- Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to Facility in writing within 30 days of the request for the Conference. The determination of a Managerial-Level Review Conference delineates the following, as appropriate:

1) The proposed resolution;

2) The facts, along with supporting documentation, on which the proposed resolution was based.

3) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;

4) A statement describing the status of each claim involved in the dispute; and

5) If the determination is not in concurrence with Facility's appeal, a statement explaining Facility's right to appeal the matter to the Michigan Insurance Bureau within 120 days after receipt of BCBSM's written response to the Conference, as well as Facility's option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving issues of Medical Necessity that are resultant from medical record reviews, Facility may submit a written request for an External Peer Review if Facility is dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, Facility can request a review by an external peer review organization to review the medical record in dispute. Facility will normally be notified of the determinations made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon Facility and BCBSM.

If BCBSM's findings are upheld on appeal, Facility will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of Facility's right to appeal any Medical Necessity issues to the Insurance Bureau or to initiate an action on those issues in a state court.

Facility's request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

INTERNAL REVIEW COMMITTEE

For disputes involving administrative and/or billing and coding issues, Facility may submit a written request for a review by the BCBSM Internal Review Committee which is composed of three members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM's response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. Facility, or Facility's representative upon Facility's written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Director, Utilization Management
Mail Code J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Facility is dissatisfied with the determination of the Internal Review Committee, Facility may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's Board of Directors) or directly to the Michigan Insurance Bureau; or initiate an action in an appropriate state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Facility may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee), a subcommittee of the BCBSM board of directors composed of BCBSM participating professionals, community leaders, and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. Facility must represent himself or herself at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

Director, Utilization Management
Mail Code J 423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Facility is dissatisfied with the determination of the Provider Relations Committee, Facility may appeal the determination to the Michigan Insurance Bureau, or initiate an action in an appropriate state court.

MICHIGAN INSURANCE BUREAU

Informal Review and Determination

If Facility is dissatisfied with BCBSM's response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if Facility believes that BCBSM has violated a provision of either Section 402 or 403 of Public Act 350, Facility shall have the right to submit a request to the Michigan Insurance Bureau for an Informal Review and Determination.

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of Public Act 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Michigan Insurance Bureau
Post Office Box 30220
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Insurance Bureau. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Insurance Bureau shall issue its determination.

Contested Case Hearing

If dissatisfied with the Insurance Bureau's determination, either Facility or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Insurance Bureau's determination is mailed, and shall be mailed to the Insurance Bureau at the same address found in the prior step.

CIVIL COURT REVIEW

Either Facility or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

STATE COURT SYSTEM

Also, as noted above, at any time after the completion of the Written Complaint or Reconsideration Review and Management Review Conference steps, Facility may attempt to resolve the dispute by initiating an action in the appropriate state court.

ADDENDUM D

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of Members and the confidentiality of personal data, personal information, and Provider financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. that requires BCBSM's board of directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of personal data".

In adopting this policy, BCBSM acknowledges the rights of its Members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; and to know it will not be shared with others except for legitimate business purposes or in accordance with a Member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a Member, that is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a Member, including an automated or computer accessible record, containing information such as an address, age/birth date, coordination of benefits data, that is maintained or stored by a health care corporation.

The term "Facility financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain Facility financial data and information as confidential.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to Members will notify Members of these routine uses and contain the Member's consent to release data for these purposes. These forms will also advise the Members of their rights under this policy.

Upon request, a Member will be notified regarding the actual release of personal data.

BCBSM will not release Member specific personal data except on a legitimate need to know basis or where the Member has given specific authorization. Data released with the Member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the Member executes in writing another prior and specific informed

consent authorizing the additional release. Where protected by specific statutory authority, Member specific data will not be released without appropriate authorization.

Experience-rated and self-funded customers may obtain personal data and Facility financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to customers will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

ADDENDUM E

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Facility will furnish a claim or report to BCBSM in the form and manner BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge to BCBSM or Member, with complete and accurate information, including diagnosis with revenue/procedure codes approved by BCBSM, and such other information as may be required by BCBSM to adjudicate claims.

Facility will use a provider identification number/facility code acceptable to BCBSM for the billing of Covered Services. Facility will only bill BCBSM for services provided by the Approved Site.

Facility agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for Covered Services by requesting information from Members, including but not limited to information pertaining to workers' compensation, other group health insurance, third party liability and other coverages. Facility further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Facility is aware the patient has primary coverage with another third party payer or entity, Facility agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Facility shall promptly report to BCBSM any overpayments Facility receives resulting from BCBSM claims payment errors or Facility billing errors, and agrees BCBSM will be permitted to deduct overpayments, whether discovered by Facility or BCBSM, from future BCBSM payments. BCBSM shall provide an explanation of the credit action taken.

SERVICES FOR WHICH FACILITY MAY BILL MEMBER

Facility may bill Member for:

1. Noncovered Services, unless the service has been deemed a Noncovered Service solely as a result of a determination by a Physician acting for BCBSM that the service was not Medically Necessary, in which case, Facility assumes full financial responsibility for the denied claims. Facility may bill the Member for claims denied as Medically Unnecessary only as stated in paragraph 2., below;

2. Services determined by BCBSM to be Medically Unnecessary, where the Member acknowledges that BCBSM will not make payment for such services, and the Member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;

3. Covered Services denied by BCBSM as untimely billed, if all of the following requirements are met:

    a. Facility documents that an acceptable claim was not submitted to BCBSM within 12 months of performance of such services because a Member failed to provide proper identifying information; and

    b. Facility submits a claim to BCBSM for consideration for payment within three months after obtaining the necessary information.

ADDENDUM G

UTILIZATION REVIEW AND CLAIMS PAYMENT AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Members' medical records or other pertinent records of Facility to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Facility for the reasonable copying expense incurred by Facility where Facility copies records requested by BCBSM in connection with BCBSM audit activities.

Facility shall prepare and maintain all appropriate records on all Members receiving services. Facility shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to Facilities by BCBSM, and such requirements subsequently developed that are communicated to Facility prior to their implementation, and as required by state and federal law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verification of services provided, Facility's adherence to BCBSM's published policies, Medical Necessity of services provided, and appropriateness of revenue/procedure codes reported to BCBSM.

III. Time

BCBSM may conduct on-site inspections and audits during Facility's regular business hours. Facility agrees to allow such on-site inspections and audits within 30 days of the request by BCBSM. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery/Payment of Interest

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria, services not verified in Facility's records, services not billed in accordance with BCBSM's published policies, services provided by a site that was not an Approved Site, and services that are not Medically Necessary as determined by BCBSM. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, revenue/procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries. Facility agrees BCBSM will be permitted to deduct such overpayments from future BCBSM payments. BCBSM shall provide an explanation of the credit action taken and may continue deductions until the full amount is recovered. In audit refund recovery situations, where Facility appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, whichever occurs first. If audit refund recoveries and other overpayment obligations are not fully repaid over the course of one

month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.

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Attachment "E"

Attachment E

STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Ambulatory Surgical Facilities
Remedial Provider Class Plan Determination
Report pursuant to P.A. 350 of 1980
_____/ No. 01-021-BC

Issued and entered
This 29th day of March, 2001
by Commissioner Frank M. Fitzgerald

ORDER DETERMINING GOAL ACHIEVEMENT OF BLUE CROSS BLUE SHIELD OF MICHIGAN REMEDIAL AMBULATORY SURGICAL FACILITY PROVIDER CLASS PLAN

BACKGROUND

On July 6, 1999, the Commissioner issued Order No. 99-117-BC. This order provided written notice to Blue Cross Blue Shield of Michigan (hereafter BCBSM), health care providers and other interested parties of his intent to make a determination with respect to the Ambulatory Surgical Facility (ASF) Provider Class Plan for the calendar years 1996 and 1997. Order No. 99-177-BC also called for persons to submit comments regarding the Plan to the Insurance Bureau (now called the Office of Financial and Insurance Services, or OFIS) in accordance with MCL 550.1505(2). A Notice of Hearing was attached to the Order scheduling a public hearing for Wednesday, August 23, 1999 that gave interested parties a reasonable amount of time to prepare testimony with regard to the ASF Provider Class Plan.

In an Order dated March 30, 2000, the Commissioner determined that the ASF plan had failed the P.A. 350 quality and access goals and required BCBSM to rewrite the plan pursuant to MCL 550.1510. In accordance with MCL 550.1511, BCBSM had six months to redraft the ASF Provider Class Plan. As required by MCL 550.1505(1), BCBSM established and implemented very inclusive procedures for obtaining advice and consultation from providers, subscribers and purchasers in developing this remedial plan. To allow time to conduct 2 large advisory meetings and to circulate draft revisions to the participants, BCBSM requested an extension of 90 days, as allowed by MCL 550.1512, in order to complete the remedial plan.

With the extension, BCBSM's remedial ASF Provider Class Plan was due by December 29, 2000. OFIS received the Plan on December 29, 2000. On January 3, 2001, OFIS sent all interested parties a copy of the remedial provider class plan and accepted written advice and consultation with respect to the remedial plan, through January 31,2001, as required by MCL 550.1513(3).

MCL 550.1513(1), requires the Commissioner to take no more than 90 days to examine the plan and determine if the plan submitted by BCBSM on December 29, 2000 substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the findings made by the Commissioner in his order of March 30, 2000.

DISCUSSION

BCBSM established the ASF provider class in 1992 and the Commissioner scheduled it for a first review in 1999. As a result of that review, the Commissioner required BCBSM to rewrite the ASF plan to correct the identified deficiencies. This was the first time that a commissioner had ever made such a determination of goal failure. As noted in the determination report, the physician, hospital, subscriber, and purchaser communities all view the role of ASFs from different perspecitives. This lack of consensus continued to be apparent in the testimony received regarding the remedial plan.

The Michigan Health and Hospital Association (MHHA) provided input on BCBSM's ASF plan on behalf of its members. The MHHA recommended that ASFs have a 3-room minimum in urban areas and at least 2 rooms in rural or sole-community areas, using the certificate of need (CON) minimum annual standard of 1,200 procedures per room. MHHA's rationale is that maintaining volumes and room sizes ensure adequate back-up facilities are available, that ASFs are maintaining the volume identified in their original CON request, and that services available elsewhere are not duplicated in the community. The MHHA believes that BCBSM's provider class plan needs to include a standard that does not differentiate between single or multi-specialty or ownership type to eliminate the unwarranted perception that bias exists toward a particular ASF category.

Not surprisingly, physicians have a very different idea of what should be contained in BCBSM's ASF plan. Much of the comments from providers and subscribers expressed concern that BCBSM's remedial plan does not do enough to level the playing field between hospital and physician-owned ASFs. It was felt that BCBSM's ASF remedial plan should be restructured to truly create equity in the marketplace by encouraging competition and the highest quality of care at the fairest price.

Other concerns expressed by ASF providers and the Michigan Ambulatory Surgical Association (MASA) focused on BCBSM's proposed requirement that multi-specialty and single-specialty facilities maintain a minimum number of operating rooms and provide a minimum of 1,200 cases or 1,600 hours per operating room per year. It was also felt by providers that the remedial plan does not provide nonparticipating providers enough transition time to allow physicians to change how they schedule surgeries so that ASFs will be able to meet BCBSM's minimum volume requirements during the first re-certification period.

While the Commissioner acknowledges and considered these comments as well as all other comments received from interested parties, the Commissioner draws his conclusions based on the totality of the information available.

MCL 550.1504(1) requires, in pertinent part, a health corporation to "contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services . . . ." In the Commissioner's March 30, 2000 determination report, although the cost goal was met, BCBSM was found not to have met the quality and access goals in its Ambulatory Surgical Facility Provider Class Plan. However, in the remedial plan filed on December 29, 2000, all three elements were again reviewed to determine whether they met all applicable the statutory requirements.

COST GOAL

The Commissioner found in his determination report of March 30, 2000 that BCBSM's ASF provider class plan achieved this goal during the 2-year period under review. The Commissioner concludes that the rewritten plan will continue to achieve this goal, since the reimbursement methodology is unchanged from the original plan.

In order to meet the cost goal, BCBSM was limited in the rate of increase in total payments per member for ambulatory surgical facility providers to the compound rate of inflation and real economic growth as specified in P.A. 350. The reimbursement arrangements in the original plan yielded a 2-year average increase in costs of 3.4%, which was only 88% of the maximum increase of 3.9% allowed by the cost goal calculation.

Since the reimbursement methodology is unchanged in the remedial plan, it is reasonable to conclude the rewritten plan will also achieve this objective and will keep cost increases below the compound rate of inflation and real economic growth. Also, while the revised evidence of need (EON) standards in the rewritten plan will increase the number of participating facilities, it appears likely

BCBSM will do so in a measured way that will not be counterproductive to containing overall health care costs (see page 35 of the March 30, 2000 determination report).

It is important for BCBSM to provide equitable reimbursement to ASF providers in return for high-quality services that are medically necessary. Both the original and the remedial ASF provider class plans have the same reimbursement for ASFs regardless of their ownership. This is clearly equitable. Also, as noted on page 37 of the determination report, BCBSM is reducing the differential in reimbursements between ASFs and hospital outpatient departments, which increases the equity of the payment between the ASF and the hospital provider class plan.

ACCESS GOAL

The March 30, 2000 determination report found that BCBSM failed to achieve this goal which states "there will be an appropriate number of providers through this state to assure the availability of certificate covered health care services to each subscriber." After review of the remedial plan, the Commissioner concludes that the plan now achieves this goal.

The March determination report identified as the main access deficiencies BCBSM's failure to use reasonable standards in applying its evidence of need (EON) criteria and its failure to apply the EON standards uniformly. BCBSM has substantially overcome these deficiencies in the rewritten plan by completely rewriting the EON standards, called qualification standards in the remedial plan, and by providing for transition periods in the application of these standards for both currently participating and nonparticipating providers that will begin "leveling the playing field" during the current year. Although it is clear from the advice and consultation received by the Commissioner that the new qualification standards are not warmly received by all interested parties, the Commissioner concludes that they are objective and reasonable, they overcome the deficienies identified in the review, and they incorporate many of the recommendations found on pp. 21-22 of the March 2000 determination report.

Also, although some nonparticipating providers advised that the remedial plan does not include enough transition time to allow physicians to change how they schedule surgeries so that ASFs are able to meet BCBSM's minimum volume requirements during the first re-certification period, the Commissioner is satisfied that the transition period will allow enough physician owned ASFs to participate during the first year of the remedial plan to substantially meet the acess goal and objectives.

The other main access deficiency identified in the termination report was a lack of participating facilities in certain areas of the state (determination report, page 11) based on BCBSM's participation rates during 1996 and 1997. Based on data provided by BCBSM participation criteria in the remedial plan, it appears that the likely result of participation rates during the first year of the remedial plan will be as follows:

Region	1996 Total Licensed Providers	1996 Par Rate	1997 Total Licensed Providers	1997 Par Rate	Total Licensed Providers	First Year Remedial Plan Est. Par Rate
1	28	46.4%	30	40.0%	30	30.0%
2	1	00.0%	1	00.0%	1	00.0%
3	4	00.0%	5	20.0%	3	66.7%
4	2	00.0%	4	25.0%	3	33.3%
5	7	14.3%	7	28.6%	7	71.4%
6	5	40.0%	5	40.0%	6	66.7%
7	2	100%	2	100%	2	100%
8	1	00.0%	1	00.0%	1	100%
9	2	00.0%	3	00.0%	3	33.3%
Statewide	53	35.8%	59	35.6%	56	44.6%

In finding that BCBSM failed to achieve the access goal, the determination report cited BCBSM's low participation rate. For the review period, the participation rate was below 36% of all licensed ASFs. BCBSM also provided participation data on a more limited data set that included only ASFs with five areas of surgical care. Even in this limited data set, BCBSM's participation rate was below 50%. (See page 9 of the March 30, 2000 determination report).

The remedial plan substantially overcomes this deficiency and substantially achieves the access goal by increasing the participation rate by 25% in the first year of the remedial plan over the participation rate in the 1996-97 review period. P.A. 350 does not define any particular measure of participation as indicative of adequate access to the certificate covered services available through any provider class. Consequently, achievement of the access goal cannot be determined by attaining any certain participation percentage, unlike the numerical simplicity of the cost goal. However, a significant increase in provider participation is indicative of substantial achievement. In this case, BCBSM increased its participation from only one-third of licensed facilities to nearly one-half of licensed facilities, with much of it concentrated in underserved areas.

In absolute numbers of participating providers, the remedial plan is expected to raise the total number of participating ASFs from a statewide 1996-97 average of

20 during the review period to 25 in the first year of the remedial plan. More importantly, the imbalance between participation with ASFs owned by hospitals and those owned by physicians is significantly narrowed, with the number of physician-owned ASFs expected to increase by 800%, from only 1 (with whom BCBSM only participated because of a court order) during the review period to 8 during the first year of the remedial plan.

To achieve the increase in participation by physician-owned ASFs, the remedial plan uses reasonable standards and applies them consistently so that BCBSM does not deny participation on the basis of ownership of a facility. The standards in the remedial plan no longer allow hospitals to transfer operating rooms to outpatient facilities. This substantially overcomes a deficiency noted in the March, 2000 determination report (see second bullet, page 20).

The requirement that a facility must perform at least 5 surgical categories (out of 11 BCBSM-established categories) has been eliminated. BCBSM will now participate with single-specialty ASFs that otherwise meet its participation requirements.

The revised EON standards in the remedial plan also substantially incorporate the recommendations on pages 21-22 of the March 30, 2000 determination report. The intent of these revised standards is to increase the likelihood that the new provider class plan will meet the access goal, and the Commissioner believes these goals are now met. These revised standards include developing different EON criteria for single-specialty clinics, using a minimum number of procedures per room in computing EON, and eliminating the trading of operating rooms from the EON calculation.

Because of the greater equity in the qualification standards and their application guidelines in the remedial plan, the increase in the number of physician-owned ASFs will be counterbalanced by a slight decrease in the number of hospital-owned ASFs from an average of 19 during the review period to 17 during the first year of the remedial plan.

Although statewide participation rates are a useful measure of access to ASFs, regional participation is an even more important measure of the availability of ASFs throughout the state. The remedial plan achieves significant increases in participation in a number of regions, including the Upper Peninsula and Northern Lower Michigan, as noted on page 11 of the March 31, 2000 determination report. The remedial plan dramatically increased participation rates in rural areas such as these by adopting a lower minimum operating room standard in recognition of the unique needs of rural communities.

QUALITY GOAL

The March, 2000 determination report found that BCBSM failed to meet this goal, which requires that providers will meet and abide by reasonable standards of health care quality. Factors underlying this determination included BCBSM's failure to review or re-certify ASF's compliance with the EON standards, BCBSM's failure to communicate quality standards clearly to providers, and a BCBSM audit process that does not really measure the quality of the facility services provided. After review of the remedial plan, the Commissioner concludes that the plan now achieves this goal.

In the remedial plan, BCBSM sets forth policies intended to assure that all ASFs, whether currently participating or applying for participation, must meet the same qualification standards on an on-going basis. It provides that facilities that fail to meet the standards will not receive or maintain participating status. This substantially overcomes BCBSM's failure to re-certify, as found in the March, 2000 determination report.

None of the public input received made comment on whether the certification period should be 3 years, as suggested in the determination report. Instead, public input focused on BCBSM's proposal that facilities be re-certified on an annual basis as it was felt that BCBSM's policy would result in a revolving door of qualifying facilities and have a negative impact the stability of BCBSM's provider network. Based on the advice received by the Commissioner and his review of the remedial plan, it appears that there is no certainty as to the ideal length for a re-certification period. It is in not in BCBSM's interest to propose a re-certification period that it expects to lead to unstable networks with constant turnover. If annual recertification proves to be too frequent, BCBSM can modify the length of the period to correct any problems.

The remedial plan also contains several new objectives that address the communication deficiencies. These include at least twice yearly meetings with the ambulatory surgery facilities liaison committee to allow providers the opportunity to discuss issues of quality of care, medical necessity, participation standards, etc., and the regular provision of information to all participating providers with regard to change in payable services, billing requirements, etc. The remedial plan no longer relies on BCBSM's audit process as the sole measure of the quality of the services provided. Over the past year, BCBSM has held two meetings with ASFs. Representatives of all licensed ASFs were invited to both of these meetings, as well as the Michigan Health and Hospital Association, the Economic Alliance, and other interested parties. There were approximately 60 invitees to each of these meetings. In one meeting, roughly 35 people attended; in the second meeting, there were approximately 45 attendees.

A new objective in the remedial plan is to assess member satisfaction with ambulatory surgical facility services. It also incorporates most of the recommendations in the determination report for ensuring that the remedial plan meets the quality goal, including the organization of a liaison committee, clear communication of participation criteria, and development of methods to gauge subscribers' preferences.

After an extensive review of the remedial plan and all related documentation, both from BCBSM and from interested parties, the Commissioner notes that perhaps BCBSM may want to revise what provider types may be included in its provider classes.

P.A. 350 vests in BCBSM the services for which it will develop provider class plans. There is no absolute requirement that this ASF provider class plan will be independently presented. A separate surgical provider class plan could contain issues presented in this ASF provider class plan.

The preparation and review of all provider class plans are time-intensive undertakings for everyone involved. Although the issues presented in this plan are important, they can receive appropriate and timely treatment in the future as part of a more comprehensive provider class plan.

The Commissioner strongly encourages BCBSM to consider, in the future, the creation of a provider class plan for all surgical services. Doing so would promote administrative efficiency and better serve the health care needs of Michigan's citizens.

ORDER

Therefore, it is ORDERED that:

1. The ambulatory surgical facilities provider class plan as filed by BCBSM on December 29, 2000 substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings made by the commissioner in the March, 2000 determination report. The plan is therefore retained and placed into effect, as provided by MCL 550.1506.

2. Pursuant to MCL 550.1510(2) of the Act, the Commissioner shall notify BCBSM and each person who has requested a copy of the Commissioner's determination in this matter by certified or registered mail.

3. Appeals may be filed pursuant to MCL 550.1515. Any request for such appeal shall be made within 30 days after receipt of the notice, as given under MCL 550.1513(3).

The commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary, and appropriate.

Frank M. Fitzgerald
Commissioner

Attachment "F"

Attachment "F"

STATE OF

DEPARTMENT OF CONSUM

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

Attachment F

In the matter of the Ambulatory Surgical Facilities
Provider Class Plan Modification Determination
Report Pursuant to P.A. 350 of 1980

/ No. 02-003-BC

Issued and entered
This 31st day of January, 2002
By Frank M. Fitzgerald

ORDER APPROVING BLUE CROSS BLUE SHIELD OF MICHIGAN MODIFICATION TO THE AMBULATORY SURGICAL FACILITIES PROVIDER CLASS PLAN

BACKGROUND

On July 6, 1999, the Commissioner of Insurance issued Order No. 99-117-BC, giving notice to Blue Cross Blue Shield of Michigan (BCBSM), and to each person having requested a copy of such notice, of his intent to make a determination with respect to the ambulatory surgical facilities (ASF) provider class plan for calendar years 1996 and 1997. After analyzing all available information, including the input obtained in accordance with MCL 550.1505(2), the Commissioner's determination with respect to his review of the ASF provider class plan in effect during calendar years 1996 and 1997 was set forth in Order No. 00-007-BC dated March 30, 2000.

In his order of March 30, 2000, the Commissioner found that BCBSM's ASF provider class plan did not substantially achieve the access and quality of care goals as provided in MCL 550.1504. Inasmuch as BCBSM failed to demonstrate that its failure to meet either of these goals was reasonable, the determination report was issued pursuant to MCL 550.1510(1)(c). This finding required BCBSM to transmit, in accordance with MCL 550.511(1), a remedial ASF provider class plan that substantially achieves the goals, achieves the objectives and substantially overcomes the deficiencies enumerated in the determination report within a six month period. BCBSM requested an extension of 90 days to file a remedial plan, as provided by MCL 550.1512, to allow time to conduct two large advisory meetings and to circulate draft revisions to participants. The

Commissioner considered BCBSM's request for the 90-day extension to file the remedial plan and granted BCBSM an extension through December 29, 2000.

The Office of Financial and Insurance Services (OFIS) received BCBSM's remedial plan on December 29, 2000. On January 3, 2001, OFIS sent all interested parties of record a copy of the remedial ASF provider class plan, requesting that written advice and consultation with respect to the remedial plan be filed with OFIS by January 31, 2001.

After an extensive review of BCBSM's remedial ASF provider class plan conducted pursuant to MCL 550.1513(1), the Commissioner found that the remedial ASF provider class plan filed by BCBSM on December 29, 2000 substantially achieved the goals, achieved the objectives and substantially overcame the deficiencies enumerated in the findings made by the Commissioner in the March 30, 2000 determination report. As such, BCBSM's remedial ASF provider class plan was retained and placed into effect in accordance with MCL 550.1506.

On December 17, 2001, BCBSM filed modifications to the ASF provider class plan with the Commissioner for approval. BCBSM is proposing two substantive modifications. The first modification to the plan would provide for an extension of the Evidence of Need (EON) transition period. In essence, this modification would grant a six-month extension of time to meet BCBSM's EON standard to all currently participating ASFs that do not meet BCBSM's EON standard but meet all of its other qualification standards. During the extended EON transition period, nonparticipating ASFs would be allowed to qualify for participation based on their most recent six months volumes. The second modification to the plan would change the recertification period from once every year to once every other year. Under the recertification process, all providers must demonstrate that they meet BCBSM's participation requirements in order to continue participating with BCBSM.

DISCUSSION

MCL 550.1508(1)(a) and (b) provides that BCBSM may modify a provider class plan under the following circumstances: "(a) If the plan was prepared by the health care corporation and is not a plan prepared pursuant to section 511(1) or 515(4). However, the modification shall not take effect until after the modification has been filed with the commissioner; (b) in all other cases, if the modification has been filed with and is agreed to by the commissioner."

Since the plan that BCBSM is proposing to modify was not prepared pursuant to Section 511(1) or 515(4), then the modification that BCBSM is proposing falls under Section 508(1)(b) and must therefore be agreed to by the Commissioner before it can become effective.

Pursuant to MCL 550.1508(2), "In developing plan modifications, a health care corporation shall obtain advice and consultation from providers in the relevant provider class and from subscribers pursuant to section 505. Before agreeing to plan modifications under subsection (1)(b), the commissioner shall obtain advice and consultation pursuant to section 505(2)." Advice and consultation was sought by OFIS through a posting of the proposed modifications on the OFIS website. Written notice seeking advice and consultation was also sought from all persons who had previously expressed an interest in BCBSM's ASF provider class plans. Written input was accepted from January 7 through January 23, 2002.

Although no subscribers responded, input was received from providers by BCBSM pursuant to an October 29, 2001 provider input meeting hosted by BCBSM. This input was summarized by BCBSM, and the summary was provided to OFIS. Copies of written comments received by BCBSM were also provided to OFIS. The following is a summary of all the comments received by OFIS:

Summary of Comments from Providers Attending BCBSM Meeting

Thirty individuals representing 11 hospitals and 11 physician-owned facilities attended BCBSM's provider input meeting held on October 29, 2001. BCBSM summarized the outcome of the meeting stating that the majority of the providers attending the meeting supported the amendments, as they would help increase network stability. However, they also said that the amendments do not go far enough. They felt the amendments should better address the definition of rural versus urban; allow providers with multiple facilities to combine volumes; and extend the transition period for 2 years (rather than six months).

Some providers stated that they were generally opposed to any sort of evidence of need volume or operating room requirements. One provider indicated that the only fair long-term solution is to lower the volume and operating room requirements "across the board". Two providers (one hospital and one not-hospital) stated that they did not support the amendments because they felt that they would result in further grandfathering of existing facilities that do not meet current standards.

Written Comments Received by BCBSM

Three letters from non-hospital facilities are nearly identical. These letters state that BCBSM's proposed change to the EON perpetuates BCBSM discrimination against independently owned ASFs in violation of 550.1502. They believe that the plan approved by OFIS should be enforced exactly as written, and they do not support modifications to the plan unless the EON is completely eliminated for all ASFs. In addition, the re-certification program is completely inconsistent with BCBSM's prior stated position that promoted the idea that ASF size and volume was somehow a "quality and safety" issue. One other non-hospital ASF wrote specifically about the re-certification program. That ASF still contends that BCBSM's re-certification program has no scientific, measurable link. If the re-certification program based in volume is such an important measure of safety and quality, why is BCBSM proposing to change it?

Two other letters were from other non-hospital ASFs. The sentiments include the same above discussion and go on to speak about how the whole process is a political one rather than one based on logic or scientific data. They believe that it would be more reasonable to adjust the EON to 800 cases (the average number of ASF cases per surgical room in 1999) and eliminate the minimum room requirement. Doing this would eliminate the need for any rural adjustment. They believe that this change would result in at least 34 ASFs qualifying for participation, bringing the par rate to between 50-70%.

The last letter was from a hospital-owned ASF. This ASF supports the amendments but does not believe that the amendments go far enough. There is no rational connection to cost, quality or access for a hospital-based ASF to have to close surgery rooms when it performs 3,600 procedures and has three or more operating rooms. Second, decertifying hospital based ASFs will disrupt patient care. Also those to be terminated are multi-specialty when the new facilities accepted are mostly single specialty. Third, while a numerical measure is a good proxy for quality for some services like transplants or open-heart surgery, it is not a credible indicator for low risk ambulatory care services performed in an ASF. Accreditation and affiliation with licensed and accredited hospitals are far better indicators. Requirements such as integrated medical staff, common medical record, common grievance, administration, clinical oversight and financial integration are used to evidence a level of integration to assure quality. These are the things that Medicare and other insurers require. Lastly, payment for services are set by billing code no matter whether done in a hospital based or freestanding ASF. Currently there is a shortage of multi-specialty ambulatory services. The growth of hospital affiliated multi-specialty ambulatory surgery capacity reduces overall costs. Loss of such capacity increases cost. Most

importantly, having to close operating rooms in operating ASFs results "in a significant waste of fully paid capital resources".

Comments Received by OFIS

The physician owner of one ASF claims that the modifications are an attempt to circumvent the appeal process. The access goal wasn't met in the original plan, the remedial plan still won't meet the access goal if the modifications are approved.

One person wrote on behalf of three non-hospital ASFs that were granted approval to participate after acceptance of the remedial plan. These three ASFs believe that the modifications are fair and resolve the concerns regarding physician pattern changes.

The physician owner of yet another ASF indicates that the merits of the CON (certificate of need) legislation are currently being reviewed in the legislature. He claims that the Federal Trade Commission has gone on record in opposition to the standards on which the EON is based. As far as access, participation rates did not increase because of the restrictive EON standards. The remedial plan is fundamentally flawed. As far as quality, there is no scientific evidence that the number of rooms or procedures is linked to the quality of patient outcomes. He claims that there are currently six hospital ASFs that don't meet the minimum number of rooms and 4 hospital ASFs that don't meet the volumes, yet they are considered facilities with high enough quality for BCBSM to participate with them right now. As far as the transition period and re-certification periods – either the EON requirements and re-certification period are quality standards or they are not. There are a number of non-hospital based ASFs that reclassified themselves from multi-specialty to single specialty; one ASF delicensed an operating room that cost $1 million to build and license. Another ASF is investing $3 million in an expansion plan. Overall, this provider estimates that non-hospital ASFs have made $10 million in financial sacrifices while hospital ASFs have sacrificed nothing. In his opinion, no hospital based ASFs have made attempts to change anything. Lastly, this provider speaks about inequity. If hospitals had to meet the same BCBSM EON criteria, 93% would not meet the criteria. He noted that the Michigan Department of Community Health classifies all operating rooms (hospital and ASF) the same.

A representative of two other physician-owned ASF reiterated these same comments. The first person also added that the only modifications that should be allowed are to eliminate or modify the EON requirement. It should be noted that this ASF meets the BCBSM participation requirements but chooses not to participate with BCBSM. The second person added his claim that BCBSM's

modification is just a "band-aid" solution of continuing to participate with non-qualifying hospital facilities to increase the participation rates. It states it would be better to use the average 1999 volume data of 800 cases per room in setting the EON. That would still leave par rates at less than 70%.

A hospital-based ASF supports the transition period, but continues to be concerned about the overall ASF plan. This provider fails to see how reducing its operating rooms from to 6 to 4 at one ASF and from 5 to 3 at another site will reduce cost, improve quality or improve access. This provider wants another amendment to "preserve patient access to existing ambulatory surgery facilities so long as the facility has at least 3 operating rooms and the 3,600 procedure threshold is met" (in order to participate).

Another physician-owned ASF now participating with BCBSM notes that OFIS continues to let BCBSM do whatever it wants; this person believes there is no evidence that the EON promotes quality of care. Public input is "like shouting down an empty well and the only sounds we hear in return are our voices echoing back at us." This person believes the EON process is illegal and that modification of an illegal provision is still illegal.

Lastly, a physician from another hospital not affiliated with any ASF states he believes that the remedial plan should remain intact and the modifications rejected because it has only been 9 months since the modified plan was put into effect. He asks OFIS to remember the major objective of PA 350 when looking at the modifications was to ensure the delivery of high-quality health care services while controlling costs. A well-defined EON transition period (which the remedial plan already had) was to have leveled the playing field. Extending the transition period will likely further increase the number of participating facilities and thus increase costs. In this time of budgetary shortfalls, increases in cost should not be allowed to continue. OFIS should deny BCBSM's modifications. Further, the re-certification period change should not be allowed either. If surgical volume is directly related to the health care quality as OFIS claims, and if quality is a major PA 350 goal, then annual re-certification is a necessity, not an option.

ANALYSIS

MCL 550.1504(1) requires a health care corporation to "contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to and reasonable cost and quality of health care services". One of the goals that must be met under the reimbursement arrangement is to ensure "an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber".

In the Commissioner's order determining the goal achievement of BCBSM's remedial ASF provider class plan dated March 29, 2001, it was noted that in the first year of BCBSM's remedial plan, the estimated participation rate was to have increased from 36% to 45%. According to recent statistics provided by BCBSM, the current participation rate is 53%. If the Commissioner does not agree to BCBSM's proposed modifications to the ASF class plan, access will deteriorate for BCBSM members by 10 facilities, and the participation rate will be reduced to only 37% -- only 1% higher than the participation rate before the remedial plan was placed into effect. Even if the Commissioner agrees to BCBSM's proposed modifications, the participation rate will still be reduced from the current 53% to 47% (see attached document to this order).

Further, the Commissioner is concerned over the quality and continuity of care provided to BCBSM's members. If BCBSM were forced to abruptly departicipate with these 10 ASFs, any BCBSM member who might have had a surgical procedure already scheduled would have to cancel that procedure, locate another facility that could perform the surgery, and be forced to wait an additional period before the medically-necessary service could be performed. Regardless of the differences in opinion among the provider community regarding BCBSM participation requirements for ASFs, this seems patently unfair to BCBSM's members needing medical services.

Therefore, the Commissioner concludes it is in the best interest of BCBSM's members to approve the proposed modifications because the modifications will improve continuity of care and access to care for certificate-covered services.

ORDER

Therefore, it is ordered that:

1. The modifications proposed by BCBSM to the ambulatory surgical facility provider class plan are hereby agreed to by the Commissioner, as provided under MCL 550.1508(1)(b).

2. BCBSM is hereby given notice that if it does not file a new or modified provider class plan by April 1, 2003, that includes a revised method for determining eligibility for participation which ensures an adequate, stable ASF network of providers, the Commissioner will commence a review of this plan pursuant to the provisions of MCL 550.1509.

3. BCBSM and each person who has requested a copy of the Commissioner's determination in this matter shall be provided with a copy by certified or registered mail.

4. An appeal of this order may be filed pursuant to MCL 600.631, MCR 7.104 and MCR 7.101 within 21 days after the date of this order.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.

Frank M. Fitzgerald
Commissioner

Attachment A

Provider Class Region	Total Providers*	Currently Participating Providers	Current Par Rate	Par Providers After Approval	Projected Par Rate	Par Providers After Transition Period	Projected Par Rate	Par Providers Without Approval	Projected Par Rate
1	35	17	49%	14	40%	13	37%	9	26%
2	1	0	0%	0	0%	0	0%	0	0%
3	4	2	50%	2	50%	2	50%	2	50%
4	3	1	33%	1	33%	1	33%	1	33%
5	7	6	86%	5	71%	5	71%	5	71%
6	6	4	67%	4	67%	4	67%	4	67%
7	2	2	100%	2	100%	2	100%	1	50%
8	1	1	100%	1	100%	1	100%	1	100%
9	3	0	0%	0	0%	0	0%	0	0%
	62	33	53%	29	47%	28	45%	23	37%
Hosp/Non Hosp		23/10		19/10		18/10		13/10	

* Excludes providers of non-covered services (e.g., Planned Parenthood, plastic surgery)

Includes Health Care Midwest (region 5) - BCBSM doesn't intend to terminate on 2/1/02 as it has received CON approval to build 2 more ORs. ORs are not built yet but BCBSM anticipates the ORs will be built by end of transition period

3 hospitals in region one and 1 hospital in region 5 will not meet OR requirements and will be terminated 2/01/02

The only regions affected by modification approval are regions 1 and 7

BLUE CROSS BLUE SHIELD OF MICHIGAN
600 LAFAYETTE EAST
DETROIT, MICHIGAN 48226

FACSIMILE TRANSMITTAL SHEET

TO: Austin Wallace	FROM: Lisa Varnier
COMPANY:	DATE: 02/01/02
FAX NUMBER: 248-448-7966	TOTAL NO. OF PAGES INCLUDING COVER: (10)
PHONE NUMBER: 313.225.4012	SENDER'S CONTACT:PERSON Rhonda Wright
RE:	YOUR REFERENCE NUMBER:

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

** TX STATUS REPORT ** AS OF FEB 01 '02 14:32 PAGE.01

BCBSM EXECUTIVE OFC

	DATE	TIME	TO/FROM	MODE	MIN/SEC	PGS	CMD#	STATUS
15	02/01	14:28	248 448 7966	EC--S	03'23"	010		OK

Attachment "G"

Blue Cross
Blue Shield
of Michigan

Attachment G

600 Lafayette East
Detroit, Michigan 48226-2998

December 17, 2001

Ms. Susan M. Scarane
Department Specialist
Health Plan
Office of Policy and Consumer Services
Division of Insurance
611 West Ottawa Street
Lansing, Michigan 48933

Re: Modifications to ASF Provider Class Plan

Dear Ms. Scarane:

Enclosed for filing is Blue Cross Blue Shield of Michigan's (BCBSM) modified provider class plan for ambulatory surgery facilities (ASF). The modifications to the plan and provider contract were finalized after BCBSM obtained input from both providers and subscribers. BCBSM's Board of directors approved the modifications on December 12, 2001.

There are just two substantive modifications to the plan. They are:

Extension of the evidence of need transition period

Under this modification, participating ASFs that meet all qualification standards, except evidence of need (EON), will be allowed an extension of time to meet this standard. The extension will run for six months from the date the modified plan is retained by the commissioner. By the end of this period, these ASFs must have submitted their volume attestations for the most recent six months. Their data will be annualized to determine whether the EON standard has been met. If an ASF meets the standard, its participating contract will continue. If it does not, its contract will be terminated.

During the transition period, nonparticipating (applicant) ASFs will also be allowed to qualify for participation based on their most recent six months' volumes. However, at the end of this period, ASFs that have operated for more than one year will be required to qualify on a full year's experience.

Modification of recertification period from once every year to once every other year

Under this modification, recertification will occur every other year rather than every year. Thus, the first recertification period will not occur in January 2002 but in January 2003, and subsequent recertifications will occur every other year thereafter. In addition, newly contracted ASFs will not be recertified until they have participated for at least a full calendar year.

As you are aware, some participating ASFs are scheduled to have their contracts terminated February 1, 2002. The modified plan's extension of time to meet the EON standard will apply to several of these ASFs and would allow their contracts to continue for an additional six months. We are concerned that the commissioner may not make a decision to retain or reject the modified plan until after February 1, 2002, and that such a delay could create problems for our members and providers. For example, if the commissioner decides to retain the plan after February 1, 2002, BCBSM will already have terminated the ASFs' contracts. The ASFs would then be considered non-participating and would have to submit volume attestations and applications for their contracts to be reinstated. This process could take some time and would place an additional burden on the ASFs. In addition, it could disrupt BCBSM members' care because they would be unable to obtain covered services at the ASFs while they are re-applying for particpation.

Delaying a decision on the plan will also make it difficult for our members to know whether these ASFs are participating. Although they currently participate, their contracts will be terminated on February 1 if the modified plan is not retained before that date. Since it is likely that several of them will meet BCBSM's particpation requirements, they will be eligible to reapply shortly after they have been terminated. BCBSM will then reinstate their contracts. These repeated changes in participation status will most certainly confuse our members and make it difficult to schedule surgery at one of these ASFs.

Given our concerns, BCBSM requests that the commissioner retain the plan before February 1, 2002.

If you have any questions about this filing or wish to discuss it, please let contact me.

Sincerely,

Lisa M. Varnier
Assistant General Counsel
Regulatory Affairs

Cc: L. Brya

LMV/cl

Blue Shield
of Michigan

Ambulatory Surgery Facilities Provider Class Plan

REVISED: DECEMBER 6, 2001

PROVIDER CLASS

A provider class may include health care facilities or health care professionals who have a contract or reimbursement arrangement with BCBSM to render services to BCBSM's members.

Definition

An ambulatory surgery facility under this provider class plan is a Michigan licensed facility that provides surgery and related care that can be performed without requiring inpatient hospital care. An ambulatory surgery facility excludes the office of a physician or other private practice office.

Scope of Services

Ambulatory surgery facilities can perform surgeries pertaining to the following systems:

- Integumentary
- Respiratory
- Digestive
- Male genital
- Nervous
- Auditory
- Musculoskeletal
- Cardiovascular
- Urinary
- Female genital
- Eye/ocular addenda

P.A. 350 GOALS AND OBJECTIVES

Cost Goal

"Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth." The goal is derived through the following formula:

$$\left(\frac{(100 + I) * (100 + REG)}{100} \right) - 100$$

Where "I" means the arithmetic average of the percentage changes in the implicit price deflator for gross domestic product over the 2 calendar years immediately preceding the year in which the commissioner's determination is being made; and,

Where "REG" means the arithmetic average of the percentage changes in the per capita gross domestic product in constant dollars over the 4 calendar years immediately preceding the year in which the commissioner's determination is being made."

Objectives

- Limit the rate of increase in total payments per member for ambulatory surgery facilities to the compound rate of inflation and real economic growth, as specified in P.A. 350, giving consideration to Michigan and national health care market conditions.
- Provide equitable reimbursement to ambulatory surgery facilities in return for high quality services that are medically necessary.

Access Goal

"There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

Objectives

- Participate with all ambulatory surgery facilities that meet BCBSM's qualification standards.
- Move toward an increased participation rate by restructuring the qualification standards for participation.
- Minimize disruptions in patient care and physician surgical practices by allowing facilities a transition period for meeting Evidence of Necessity standards. Advise the Insurance Commissioner of the progress of each step of the transition period and implementation process.
- Recognize the unique needs of rural areas by establishing specific operating room minimums for rural ambulatory surgery facilities.
- Provide members with current addresses and telephone numbers of all participating ambulatory surgery facilities.
- Review reimbursement levels periodically and adjust as necessary.

Quality Of Care Goal

"Providers will meet and abide by reasonable standards of health care quality."

Objectives

- Apply and monitor providers' compliance with participation requirements and performance standards.
- Assess member satisfaction with ambulatory surgery facility services.

- Meet with the ambulatory surgery facilities liaison committee at least two times annually to allow facilities the opportunity to discuss with BCBSM such issues as quality of care, medical necessity, administrative concerns, participation standards, etc.

- Regularly provide all participating facilities with information on topics such as changes in payable services, group benefit changes, billing requirements, in addition to general educational materials.

- Maintain and update, as necessary, an appeals process that allows facilities to appeal individual claims disputes or utilization review audits. This process is described in Addendum C of the Ambulatory Surgical Facility Participation Agreement.

BCBSM POLICIES & PROGRAMS

BCBSM maintains a comprehensive set of policies and programs that work toward achieving the provider class plan goals and objectives. These policies and programs are designed to help BCBSM meet the P.A. 350 goals by limiting cost, maintaining accessibility, and ensuring quality of health care services to its members. To that extent, the following policies and programs may, individually or in combination, affect achievement of one or more of the P.A. 350 goals. BCBSM annually reports its performance against the goals and objectives for each provider class plan.

Provider Participation

BCBSM may issue a participating contract that covers all members of a provider class or it may offer a separate and individual contract on a per claim basis, if applicable to the provider class.

Participation Policy

Participation for ambulatory surgery facilities is on a formal basis only. Facility services rendered in a non-participating ambulatory surgery facility are not reimbursed. In order to participate, facilities must meet all of BCBSM's qualification standards.

Qualification Standards

To qualify as a participating ambulatory surgery facility, a facility must meet and continue to meet the following requirements:

- Have a physical structure other than the office of a physician, dentist, podiatrist or other private practice office, offering surgical procedures and related services that can be performed without requiring inpatient hospital care.
- Be licensed by the state of Michigan as a Freestanding Surgical Outpatient Facility (FSOF), and meet any requirements of applicable federal law.
- Be accredited as an ambulatory health care facility by at least one national accreditation organization such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), or the Accreditation Association for Ambulatory Health Care (AAAHC), or any additional accreditation organization approved by BCBSM.
- Be Medicare certified as an Ambulatory Surgery Center (ASC), or determined by Medicare to be an extension or part of a Medicare certified hospital.

- Provide surgery within at least two of the following body systems for designation as a multi-specialty ASF: integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/ocular adnexa and auditory, etc.

- Provide surgery within only one body system for designation as a single-specialty ASF: integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/ocular adnexa, auditory, etc.

- Maintain a minimum of three Michigan Department of Community Health (MDCH) designated operating rooms for non-rural multi-specialty ASFs, and a minimum of two MDCH designated operating rooms for non-rural single-specialty ASFs. Non-rural is determined by the United State's Department of Agriculture's most recent Rural-Urban Continuum Code. Facilities that have more than the minimum number of operating rooms must still meet all volume requirements described under the Evidence of Necessity standard.

- Maintain a minimum of two MDCH designated operating rooms for rural multi-specialty ASFs and a minimum of one MDCH designated operating room for rural single-specialty ASFs. Rural is determined by the United State's Department of Agriculture's most recent Rural-Urban Continuum Code. Facilities that have more than the minimum number of operating rooms must still meet all volume requirements described under the Evidence of Necessity standard.

- Patients admitted to the ambulatory surgery facility must be under the care of a licensed physician. A physician should be available on-site at all times when a patient is on the facility's premises. The ambulatory surgery facility should make provisions for patient care services that are appropriate to the needs of the patients and the community it serves.

- Have an organized medical staff, established in accordance with policies and procedures developed by the facility, that is responsible for maintaining proper standards of medical care. Membership on the medical staff must be available to qualified physicians in the community. Criteria for membership on the medical staff will be established and enforced by a credentials evaluation program established by the facility.

- Have a written agreement with at least one acute care general hospital, within a reasonable travel time, as determined by BCBSM, to facilitate prompt transfer of patients requiring hospital care. The written agreement with a hospital shall provide that copies of the facility's medical records shall be transmitted to the hospital where the patient is transferred.

- Conduct program evaluation, utilization review and peer review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components applicable to all patient services in accordance with the requirements of BCBSM and the appropriate accrediting and regulatory agencies.

- Have a governing board that is legally responsible for the total operation of the facility, and for ensuring that quality medical care is provided in a safe environment.

- Financial affairs must be conducted in a manner consistent with prudent fiscal management. Records of its transactions shall be maintained in conformity with generally accepted accounting principles, and with BCBSM billing, reporting and reimbursement policies and procedures.

- Meet the Evidence of Necessity minimum volume requirements at the time of initial application and every other year thereafter, through a recertification process. Evidence of Necessity requires that a facility operate at a minimum volume of 1200 surgical cases or 1600 hours per operating room per year[⊕].

Participation Process

A nonparticipating facility may apply for formal participation at any time. A two step application process begins by demonstrating compliance with BCBSM's Evidence of Need followed by a separate submission to demonstrate compliance with all other qualification standards. Initially, a facility must submit a completed BCBSM Evidence of Need Attestation reporting its volumes and operating rooms. Upon receiving confirmation that it meets EON standards, a facility must submit a separate application to demonstrate compliance with all other BCBSM qualification standards.

In the EON attestation, facilities that have been operational for one year will be required to submit their most recent twelve months of volume. Applicant facilities that have been operational for less than one year will be allowed to submit their most recent six months volume. The data will then be annualized.

Volume attestations must be signed by the facility owners or officers. The reports must clearly identify the type of room in which cases were performed (e.g., a licensed operating room on a sterile corridor, a dedicated endoscopy/cystoscopy room, or some other non-operating room). Procedures performed in a room not designated as an operating room on the corresponding Michigan Department of Community Health's Annual Hospital Statistical Survey will not be counted as part of the facility's overall volume.

Although the minimum volume a facility must meet is 1200 surgical cases or 1600 hours per operating room per year[⊕], this standard is adjusted for non-participating facilities to reflect that they have not had access to BCBSM's market share. The adjustment will be the greater of 25 percent of the minimum volume requirements or BCBSM's market share within the state defined Health Service Area (HSA) in which a facility is located. BCBSM market share is determined by comparing overall hospital outpatient charges in the (HSA) to BCBSM hospital outpatient charges, using the most recent available data.

Facilities that provided services to BCBSM members during the period for which they are submitting volume information may not include those cases where BCBSM is the primary payor if they wish to qualify for the BCBSM market share adjustment. If the patient has another carrier

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[⊕] BCBSM's definition of a "surgical case" and "hours of use" will be the same as that used by the Michigan Department of Community Health. The MDCH currently defines a case as a single visit to an operating room during which one or more surgical proceduresare performed. "Hours of use" is defined as the actual time an operating room is used to provide surgical services and excludes set-up and clean-up time.

or has Medicare as the primary insurer, the case may be included in the volume total even if BCBSM is the secondary or supplemental insurer.

BCBSM will send facilities notification of their EON status within 30 days of receiving their EON Attestation. Facilities meeting the EON standards will be informed that an application should be submitted, if the facility has not already done so, which demonstrates conformance to all other BCBSM qualification standards. The review will commence with the receipt of a completed application and a letter will be sent to the facility within 60 days stating their eligibility for participation. Facilities that do not meet the EON standards or the qualification standards will have review of their applications denied with a letter explaining why the application was denied.

Recertification Process

Ambulatory surgery facilities that have been participating with BCBSM for more than 12 months are required to be recertified. Beginning in the year 2003 and every other year thereafter, a facility must submit to BCBSM, by January 31st, their volume attestations reflecting at least one full calendar year of operations. A facility that does not meet the standard or does not submit its volume attestations will be sent notification by March 1 of each recertification year that it will lose its participation status on May 1 of that same year.

Upon recertification, all participating facilities will fall within one of the following categories:

Category	Result
▪ Meets the full volume requirement (1200 cases or 1600 hours per room per year) for at least one of the two calendar years between recertification periods.	▪ Maintains participation status until the next recertification period.
▪ Meets 90 percent of the volume requirement (1080 cases or 1440 hours per room per year) for at least one of the two calendar years between recertification periods.	▪ Conditional participation extension – must meet full volume requirement in at least one of the two calendar years before the next recertification period.
▪ Does not meet at least 90 percent of the volume requirement in either of the calendar years between recertification.	▪ Loses participation status on May 1 of the recertification year.

Evidence of Necessity Transition Period

A six month transition period is in effect, beginning with this plan's acceptance by the OFIS, for currently participating facilities that meet all standards except for the EON volume requirement. These facilities will have six months from the acceptance of this provider class plan to submit to BCBSM their surgical case or hour volume attestations for the most recent six months. The data will be annualized to determine whether it meets the required minimums for participating facilities.

Within 30 days of receiving a facility's attestation, BCBSM will send a letter to the facility indicating its participation status. Facilities that meet the minimum requirements of 1200 surgical cases or 1600 hours per operating room per year[⊕], as well as all other participation requirements, will maintain their participation status. Facilities that do not meet the full volume requirements of 1200 surgical cases or 1600 hours per operating room per year[⊕] will lose their participation status with 60 days notice.

During the extended transition period, new (applicant) facilities will also be allowed to qualify for participation based on their most recent six-months' volume. At the end of the extended transition period, applicant facilities that have been operational for more than one year must qualify based on a full year's volume.

- **De-licensure of Operating Rooms**

A participating or nonparticipating facility that intends to de-license one or more operating rooms to meet the EON volume requirements must notify BCBSM of this intent at the time of its initial application or at recertification. BCBSM will conditionally approve a facility for participation or recertification if: (1) the facility meets all qualification standards except the volume requirements at the time of application; and, (2) the de-licensing of rooms will result in the facility meeting the volume requirements. A facility must submit appropriate documentation that a room has been de-licensed within 60 days of BCBSM's conditional approval or the conditional approval will expire and no participation agreement will be in effect.

- **Operating Room Exchanges**

The trading of operating rooms for Evidence of Necessity purposes, in which a hospital closes one or more of its operating rooms in exchange for approval of an ambulatory surgery facility operating room, will not be allowed.

Termination of Contract

Participation shall be terminated by BCBSM with 60 days notice if an ambulatory surgery facility fails to meet minimum volume standards. A designated single-specialty facility that submits claims for services outside of its designated specialty will have its participation agreement terminated with 60 days notice. An ASF that fails to meet any other qualification standard established by BCBSM, and described in Addendum A of the Ambulatory Surgery Facility Participation Agreement, will have its participation agreement terminated with 60 days notice. Any facility found to knowingly submit false volume information will have its participation agreement immediately terminated.

[⊕] BCBSM's definition of a "surgical case" and "hours of use" will be the same as that used by the Michigan Department of Community Health. The MDCH currently defines a case as a single visit to an operating room during which one or more surgical proceduresare performed. "Hours of use" is defined as the actual time an operating room is used to provide surgical services and excludes set-up and clean-up time.

Termination of the participating agreement may also occur by either BCBSM or the facility under the terms and conditions specified in Article V of the Ambulatory Surgery Facilities Participation Agreement.

Provider Programs

BCBSM strives to ensure the appropriateness and quality of the services delivered to subscribers through a combination of communication, education, and quality assurance programs that oversee and support health care providers.

Utilization Management Initiatives

BCBSM requires that ambulatory surgery facilities develop and implement their own program evaluation, utilization management and peer review programs. These programs must:

- Assess the quality of care provided to patients to ensure that proper services are provided at the proper time by qualified individuals
- Identify, refer, report and follow up on quality of care issues and problems
- Monitor all aspects of patient care delivery

The utilization management and peer review plan must be written and must identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan including:

- Quality, content and completeness of the medical records
- Clinical performance
- Quality and appropriateness of diagnostic and treatment procedures
- Evaluation of tissue specimens
- Medication utilization
- Patient satisfaction
- Quality and appropriateness of anesthesia
- Arrangements for patients requiring hospitalization following ambulatory surgery

Education/Communications

- Participating ambulatory surgery facilities routinely receive the *Hospital & Facility News.*
- BCBSM's regional field services representatives visit ambulatory surgery facilities on-site for individualized provider education, and provide on-going assistance to facility staff.
- BCBSM meets twice annually with the ambulatory surgery facility liaison committee.
- BCBSM maintains and updates as necessary, the *Guide for Participating Ambulatory Surgery Facilities.*
- Provider participation information is available on the BCBSM corporate web page or the Provider Inquiry and Customer Service Inquiry toll-free hotlines.

Performance Monitoring

- Ambulatory surgery facilities are recertified every other year to ensure compliance with Evidence of Necessity standards. Applications and volume attestations are submitted by January 31st of each year.
- Ambulatory surgery facilities are periodically surveyed to ensure they maintain up-to-date compliance with licensing requirements and all other qualification standards.
- Suspected fraudulent activity, reported to BCBSM by providers, subscribers, and BCBSM staff, is referred to Corporate Financial Investigations for further investigation.
- Utilization review audits, when conducted, work to ensure that providers rendered services appropriately and within the scope of members' benefits.
- BCBSM will develop a satisfaction survey to assess member perceptions of the care provided at participating ambulatory surgery facilities.

Reimbursement Policies

BCBSM reimburses participating ambulatory surgical facilities for covered services deemed medically necessary by BCBSM. Determination of medical necessity is described in the attached Ambulatory Surgery Facility Participation Agreement.

Covered Services

Reimbursement for covered services provided in an ambulatory surgery facility covers services directly related to the surgical procedure, including the following items:

- Use of the ambulatory surgery facility including operating, recovery, or other treatment rooms, pre-operative areas, patient preparation areas, post-operative areas used by the patient or offered for use to the patient's relatives in connection with surgical procedures
- Nursing and technical services
- EKGs
- Drugs, biologicals, surgical dressings, supplies, splints, casts, implant prosthetics, and equipment directly related to the provision of the surgical procedure
- Materials for anesthesia
- Routine laboratory services performed on the day of the surgery, radiology services performed with equipment owned or operated by the facility
- Administrative, record keeping and housekeeping items and services

Reimbursement Methods

Payment for outpatient surgical procedures is based on one of the following three reimbursement methods:

- Price-based payment for ambulatory surgical procedures which are not commonly performed in physicians' offices, as determined by BCBSM, is based on a conversion of billed charges to costs, and a BCBSM determined surgical pricing formula.
- Statewide percentage of charges payment for procedures which are not commonly performed in physicians' offices, as determined by BCBSM, and for which BCBSM has insufficient utilization data to establish a reasonable price, is based on the approved charge multiplied by the statewide percentage of charges as determined by BCBSM.
- Nominal price-based payment for surgical procedures predominantly performed in physicians' offices, as determined by BCBSM, is based on 50 percent of the physician practice expense of the BCBSM physician fee for each procedure.

Payment for laboratory and radiology procedures is a price-based system using the technical component of the BCBSM physician fee for each procedure.

Payment for EKGs is based on a statewide percentage of charge payments.

Hold Harmless Provisions

Participating ambulatory surgery facilities agree to accept BCBSM's payment as payment in full for covered services. Member copayments and/or deductibles are subtracted from BCBSM's payment before the facility is reimbursed. Participating facilities hold members harmless from:

- Balance billing, unless the services rendered are not covered services
- Medically unnecessary services, as determined by BCBSM, unless the member acknowledges that BCBSM will not pay for the services and agrees in writing before the services are rendered to assume liability
- Financial obligation for covered services provided but not billed to BCBSM within 12 months under the circumstances specified in the Ambulatory Surgery Facility Participation Agreement

Appeals Process

Participating facilities have the right to appeal BCBSM decisions regarding individual claims disputes and utilization review audit determinations. The complete process is described in Addendum C of the Ambulatory Surgery Facility Participation Agreement.

AMBULATORY SURGERY FACILITIES PARTICIPATION AGREEMENT (Attached)

BLUE CROSS BLUE SHIELD OF MICHIGAN
AMBULATORY SURGERY FACILITY
PARTICIPATION AGREEMENT

This Agreement is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and _____, (Facility), an Ambulatory Surgery Facility, whose address is _____.

ARTICLE I
DEFINITIONS

1.1 **"Agreement"** means this Agreement, all exhibits, and addenda attached hereto, or other documents expressly incorporated herein.

1.2 **"Ambulatory Surgery Facility" or "ASF"** means a facility that provides outpatient ambulatory surgery Covered Services and that meets all the Qualifications Standards stated in Addendum A.

1.3 **"Approved Site"** means the Ambulatory Surgery Facility location specifically approved and contracted by BCBSM.

1.4 **"Certificate"** means benefit plan descriptions under the sponsorship of BCBSM or other Blue Cross and Blue Shield (BCBS) Plans, or certificates and riders issued by or under their sponsorship, or arrangements with any employer group, including any self-funded plan, where BCBSM or other BCBS Plans administer benefits; and, unless the subject of a separate agreement with Facility, any Preferred Provider Organizations (PPOs) or other alternative delivery system owned, controlled, administered or operated in whole or part by BCBSM, excluding BCBSM's subsidiaries, or by other BCBS Plans.

1.5 **"Covered Services"** means those ambulatory surgery facility services that are (i) listed or provided for in Certificates, and (ii) provided at an Approved Site.

1.6 **"Medically Necessary"** means a determination by Physicians acting for BCBSM that a Covered Service meets all of the following conditions: (i) it is rendered for the treatment, diagnosis or symptoms of an injury, condition or disease; (ii) the care, treatment or supply is appropriate given the symptoms, and is consistent with the diagnosis, "Appropriate" means that the type, level, and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment; (iii) it is not mainly for the convenience of the Member or of the Member's health care provider; (iv) it is not treatment that is generally regarded as experimental or investigational by BCBSM; and (v) it is not determined to be medically inappropriate.

1.7 **"Member"** means a person entitled to receive Covered Services pursuant to Certificates.

1.8 **"Noncovered Services"** means those services that are not Covered Services.

1.9 **"Qualification Standards"** means those criteria established by BCBSM that are used to determine Facility's eligibility to become or remain a participating Ambulatory Surgery Facility as set forth Addendum A.

1.10 **"Physician"**, for the limited purposes of this Agreement, means a medical doctor (MD), a doctor of osteopathy (DO), or doctor of podiatry (DPM), licensed in Michigan.

1.11 **"Reimbursement Methodology"** means the methodology by which BCBSM determines the amount of payment due Facility for Covered Services as set forth in Addendum B.

ARTICLE II
FACILITY RESPONSIBILITIES

2.1 **Services to Members.** Facility, within the limitations of its licensed scope of services, will provide Covered Services to Members based on requirements in Members' Certificates and as governed by the terms and conditions of this Agreement and all other BCBSM policies in effect on the date Covered Services are provided.

2.2 **Qualification Standards.** Facility will comply with the Qualification Standards established by BCBSM and further agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without 60 days prior written notice to Facility. Upon request, Facility will submit to BCBSM evidence of continuing compliance with all Qualification Standards. Notice of changes to Qualification Standards may be given as stated in Section 5.12, or, at BCBSM's option, by publication in the appropriate BCBSM provider publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility. The current Qualification Standards are set forth in Addendum A.

2.3 **Listing of Facilities.** Facility agrees that BCBSM shall have the right to include Facility's name, address and location in listings or other written documents provided for assisting Members to obtain Covered Services from a participating Ambulatory Surgery Facility.

2.4 **Claims Submission.** Facility will submit acceptable claims for Covered Services directly to BCBSM using BCBSM approved claim forms, direct data entry systems, tape-to-tape systems or such other methods as BCBSM may approve from time to time. An "acceptable claim" is one that complies with the requirements as stated in appropriately published BCBSM administrative manuals or additional published guidelines or criteria.

Acceptable claims for Covered Services shall be submitted within 12 months of the date of service. Claims submitted more than 12 months following the date of service, shall not be entitled to reimbursement except as set forth in Addendum F. Facility will endeavor to file complete and accurate claims and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum E.

2.5 **BCBSM Payment.** Facility will only look to BCBSM for reimbursement for Covered Services and will request reimbursement from Members only for applicable deductibles and copayments for Covered Services, or for services it furnishes that are not Covered Services. Facility agrees not to collect any further payment, except as provided in Addendum F. Facility may not request or require Members to sign an agreement or form to reimburse Facility for any charges in excess of BCBSM's reimbursement for Covered Services, unless otherwise stated in this Agreement. Facility may not collect deposits from Members for Covered Services. Facility may not waive copayments and/or deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member's record or where reasonable efforts to collect have failed.

2.6 **Utilization and Quality Programs.** Facility will adhere to BCBSM's published policies, procedures, and requirements regarding utilization review, quality assessment, quality improvement, patient satisfaction surveys, preauthorization, case management, disease management, or other programs established or modified by BCBSM. BCBSM agrees to furnish Facility with information necessary to adhere to such programs, policies and procedures.

2.7 **BCBSM Access to Records.** BCBSM represents that Members, by contract, as a condition precedent to receiving benefits, agree to the release of information and records to BCBSM from Facility and Physicians, including but not limited to, all medical and other information relating to their care and treatment. Facility shall obtain any further releases or waivers it believes are necessary for the purpose of providing to BCBSM Member medical and billing records related to Covered Services. Facility will release patient information and records within 30 days of BCBSM's request to enable BCBSM to process claims, to verify compliance with BCBSM's Qualification Standards, and for prepayment or postpayment review of medical records that relate to filed claims.

2.8 **Confidentiality.** Facility will maintain the confidentiality of the medical records and related information of Members as required in this Agreement and in accordance with applicable state and federal law.

2.9 **Approved Site.** Facility's Approved Site must be specifically approved by BCBSM. Facility's Approved Site is listed in the Signature Document to this Agreement.

2.10 **Records and Record Retention.** Facility will prepare and maintain all appropriate medical and financial records related to Covered Services provided to Members as required by BCBSM published policies and procedures and as required by law.

2.11 **Audits and Recovery.** Subject to all applicable laws and the confidentiality provisions set forth in this Agreement, Facility agrees that:

a.) Medical Record and Billing Reviews. BCBSM may photocopy, review and audit Facility's records to determine program compliance. Such audits include, but are not limited to, verification of services provided, adherence to BCBSM's published policies, Medical Necessity of services provided, and appropriateness of revenue/procedure codes reported to BCBSM. BCBSM is entitled to obtain recoveries based on such audits as set forth in Addendum G.

b.) Financial Audits. Facility will allow BCBSM to conduct reasonable audits of Facility's financial records. Facility will provide BCBSM with on-site access during Facility's regular business hours to financial records as may be necessary for validating Facility's compliance with Qualification Standards, or for establishing or validating appropriate reimbursement under this Agreement.

2.12 **Facility Changes.** Facility will notify BCBSM, in writing, at least 30 days prior to implementation of major changes, such as, but not limited to, changes in: (i) name; (ii) location; or (iii) ownership. Facility will also notify BCBSM within five business days of Facility's knowledge of any material changes in Facility's professional and administrative staffing; reduction or expansion of surgical services provided if relevant to BCBSM's determination of Facility's categorization as a single-specialty or multi-specialty ASF as described in Addendum A; any reduction or expansion of the number of Facility's operating rooms; licensure; accreditation; or, Medicare certification. Such prior notification of changes is required so that BCBSM may determine Facility's continued compliance with Qualification Standards and contractual obligations. Prior notification of

major program or administrative changes, such as changes in location and ownership, does not ensure continued Facility approval by BCBSM. Ownership and location changes, as well as other major changes, require specific BCBSM approval for continued participation by Facility.

Facility will also notify BCBSM of any actions, policies, determinations, or internal or external developments that may have a direct impact on the provision of Covered Services to Members. Such notification includes, but is not limited to, any legal or government action initiated against the Facility, or any of its owners, officers, directors or employees that affects this Agreement, including but not limited to any action for professional negligence, fraud, violation of any law, or against any health care license.

2.13 **Successor's Obligations.** Facility will require any prospective successor to its interest to assume liability for any amounts for which Facility is indebted to BCBSM, whether evidenced by a promissory note or otherwise. Such assumption of liability shall be one of the conditions for BCBSM approval of any successor in interest as a participating Facility. Such assumption of liability shall not release Facility from the indebtedness unless an agreement to that effect is entered into between BCBSM, the Facility, and any prospective successor, or the successor is a participating Facility and expressly agrees to assume Facility's liabilities to BCBSM.

2.14 **State and Federal Laws.** Facility will provide Covered Services in a manner which conforms to (i) all applicable federal, state and local laws, rules and regulations, and (ii) the standards of professional conduct and practice prevailing in the applicable community during this Agreement.

2.15 **Subcontracting.** Facility must have a written contract with all subcontracted staff. Facility is responsible for ensuring that the subcontracted staff (i) is qualified to perform the service they are subcontracted to perform, (ii) meets and maintains any relevant Qualification Standards, and (iii) adheres to BCBSM's published policies and procedures. Facility remains responsible for the acts or omissions of its subcontracted staff. Facility will furnish a copy of such subcontract to BCBSM upon request.

2.16 **Approved Site.** Facility's Approved Site is listed in the Signature Document.

2.17 **Transfer of Services by BCBSM.** Facility understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services, and may conduct business through representatives and agents. Facility agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

ARTICLE III
BCBSM RESPONSIBILITIES

3.1 **General.** BCBSM's payment obligations pursuant to this Agreement will be limited to Covered Services provided by Facility in accordance with the terms and conditions contained herein.

3.2 **Member Identification.** BCBSM shall provide Members with identification cards and with written information necessary to inform Members of the procedures for obtaining Covered Services from Facility and of their obligations for copayments, deductibles and Noncovered Services.

3.3 **Eligibility and Benefit Verification.** BCBSM will provide Facility with a system and/or method to promptly verify eligibility and benefit coverages of Members; provided that any such verification by BCBSM will be given as a service and not as a guarantee of payment.

3.4 **Claims Processing.** BCBSM will process claims submitted by Facility for Covered Services provided to Members in a timely fashion and in accordance with the terms and conditions contained in this Agreement.

3.5 **BCBSM Reimbursement.** Pursuant to the terms and conditions contained in this Agreement, BCBSM will make direct payment to Facility for Covered Services provided to Members according to the Reimbursement Methodology set forth in Addendum B and as in effect on the dates Covered Services are provided. Reimbursement under this Agreement will not include any amount for professional services but will be limited to facility services, nor will reimbursement include any amounts not properly payable under any coordination of benefits provisions or where another party is liable, in which case BCBSM payment will be the amount BCBSM would have normally paid for such Covered Services less any amount received by Facility from another party.

3.6 **Administrative Manuals and Bulletins.** BCBSM will provide, at no charge to Facility, one copy of administrative manuals, bulletins and such other information and documentation as shall be necessary for Facility to properly provide and be reimbursed for Covered Services provided to Members pursuant to this Agreement.

3.7 **Audits and Recovery.** Audits will be conducted and recoveries obtained in accordance with Section 2.11 and Addendum G of this Agreement.

3.8 **Appeal Processes.** BCBSM will provide an appeal process for Facility in accordance with Addendum C, if Facility disagrees with any claim adjudication or utilization review audit determination.

3.9 **Confidentiality.** BCBSM shall maintain the confidentiality of Members' records and Facility financial information of a confidential or sensitive nature in accordance with BCBSM's Confidentiality Policy in Addendum D. BCBSM will indemnify and hold Facility harmless from any claims or litigation brought by Members asserting any breach of such Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding Facility information and data, or from communicating with customers regarding aggregate data pertaining to Facility and participating Ambulatory Surgery Facilities.

ARTICLE IV
FACILITY ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

4.1 This contract is between Facility and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, Facility agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to Facility under this Agreement and no other obligations are created or implied by this language.

ARTICLE V
GENERAL PROVISIONS

5.1 **Term.** The term of this Agreement shall begin on the later of _____ or the effective date indicated on the Signature Document and shall continue until terminated as provided herein below.

5.2 **Termination.** This Agreement may be terminated as follows:

a. by either party, with or without cause, upon 60 days written notice to the other party;

b. by either party, immediately, where there is a material breach of this Agreement by Facility that is not cured within 30 business days of written notice to the other party;

c. by BCBSM, automatically and without notice, if Facility has its license or accreditation suspended, revoked, or nullified or if Facility or an officer, director, owner or principal of the Facility is convicted of or pleads to a felony or other violation of law;

d. by BCBSM, with 60 days notice, except as otherwise stated in Article V. Section 5.2c, if Facility fails to meet the Qualification Standards set forth in Addendum A.

e. by BCBSM, immediately, if Facility knowingly submits false volume data for the purposes of BCBSM's Evidence of Necessity determination;

f by either party, upon the filing of any involuntary or voluntary proceeding in bankruptcy against either party, insolvency of any party, upon the appointment of a receiver of any party, or any other similar proceeding if such proceedings are not dismissed or withdrawn within 60 days;

g. by either party, immediately, if Facility ceases providing ambulatory surgery services, ceases providing ambulatory surgery services to Members, or ceases doing business;

h. by BCBSM, immediately, at its option, if there is a change in the ownership of Facility; or

i by BCBSM if termination of this Agreement is ordered by the state Insurance Commissioner.

5.3 **Existing Obligations.** Termination of this Agreement shall not in any way affect the obligations of the Parties under this Agreement prior to the date of termination. Such obligations shall include, but are not limited to, completion of all medical records and cooperation with BCBSM with respect to any actions arising out of relationships created by this Agreement filed against BCBSM after the effective date of termination. This Agreement shall remain in effect for the resolution of all matters pending on the date of termination. Upon termination of this Agreement, BCBSM's obligation to reimburse Facility for any Covered Services will be limited to those provided through the date of termination.

5.4 **Right of Recovery.** The expiration or termination of this Agreement or any changes as provided in this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from Facility for overpayments or for recoveries based upon any audit

conducted pursuant to the terms of this Agreement. Such rights of BCBSM shall survive the termination of this Agreement.

5.5 **Nondiscrimination.** Facility will not discriminate because of age, sex, race, religion, color, marital status, residence, lawful occupation or national origin, in any area of Facility's operations, including but not limited to employment, patient registration and care, and clinical staff training and selection. Any violation of this provision by Facility shall constitute a material breach and give BCBSM the right to immediately terminate this Agreement as provided in Article V. Section 5.2b. of this Agreement.

5.6 **Relationship of Parties.** BCBSM and Facility are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement.

5.7 **Assignment.** Any assignment of this Agreement by either party without the prior written consent of the other party will be null and void, except as stated in Article II. Section 2.17 of this Agreement.

5.8 **Amendment.** This Agreement may be altered, amended, or modified at any time by the prior written consent of the parties, provided however, that BCBSM shall have the right to unilaterally amend this Agreement upon giving 90 days prior written notice to Facility, or such lesser advance notice as may be otherwise provided in this Agreement. Notice shall be given as provided in Article V. Section 5.12 of this Agreement, or, at BCBSM's option, by publication in the appropriate BCBSM provider publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility.

5.9 **Waiver.** No waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by the appropriate representatives of BCBSM or the Facility, against whom such a waiver is being sought. Any waiver of one or more of the provisions of this Agreement or failure to enforce the Agreement by either of the parties hereto shall not be construed as a waiver of any subsequent breach of the Agreement or any of its provisions.

5.10 **Scope and Effect.** This Agreement along with any attachments shall supersede any and all present or prior agreements and understandings between the parties regarding the subject matter hereof, whether written or oral, shall constitute the entire agreement and understanding between the parties and be binding upon their respective successors and assignees.

5.11 **Severability.** If any provision of this Agreement is deemed or rendered invalid or unenforceable by any state or federal law, rule, regulation or decision of any court of competent jurisdiction, the remaining provisions of this Agreement shall remain in full force and effect; provided, however, should any such invalidity or unenforceability and its removal has the effect of materially changing the obligations of either party, as in the judgment of the party affected, (i) will cause it serious financial hardship, or (ii) cause it to be in violation of its corporate Articles of Incorporation or Bylaws, such party shall have the right to terminate this Agreement upon 30 days prior written notice to the other party.

5.12 **Notices.** Any notice required or permitted under this Agreement shall be given in writing and sent to the other party by hand delivery, or postage prepaid regular mail at the following address or such other address as a party may designate from time to time.

If to BCBSM:

Provider Contracting - B715
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

If to Facility:

Address indicated on BCBSM Provider File

5.13 **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.

5.14 **Other Agreements.** BCBSM and Facility acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

5.15 **Governing Law.** This Agreement will be governed and construed according to the laws of the state of Michigan. Jurisdiction of any dispute will be Michigan.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

ADDENDA

A. Qualifications Standards

B. Reimbursement Methodology

C. Disputes and Appeals

D Confidentiality Policy

E. Service Reporting and Claims Overpayment Policy

F. Services for Which Facility May Bill Members

G. Audit and Recovery Policy

QUALIFICATION STANDARDS

To qualify as a participating BCBSM Ambulatory Surgery Facility, Facility must meet, and continue to meet the following requirements:

1. Physical Structure and Services. Facility must be a structure, other than the office of a physician, dentist, podiatrist or other private practice office, offering ambulatory surgery and related care that does not require inpatient hospital care.

2. Licensure. Facility must be licensed by the state of Michigan as a Freestanding Surgical Outpatient Facility (FSOF), and meet any requirements of applicable federal law.

3. Accreditation. Facility must be accredited under the appropriate program (i.e., ambulatory health care) by at least one national accreditation organization approved by BCBSM, such as, but not limited to:

   - Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
   - American Osteopathic Association (AOA), or
   - Accreditation Association for Ambulatory Health Care (AAAHC).

4. Medicare Certification. Facility must be certified by Medicare as an Ambulatory Surgery Center, or determined by Medicare to be an extension or part of a Medicare certified hospital.

5. Evidence of Necessity (EON). Facility meets BCBSM's Evidence of Necessity (EON) requirement at the time of initial application, and biennially thereafter through a recertification process. EON requires that Facility operates at a minimum volume of 1200 surgical cases or 1600 hours of use, per operating room per year.

   The term "volume(s)", as used in this Agreement, refers to the number of Facility's surgical cases or hours of use, per operating room per year. For BCBSM's purposes, the definition of a "surgical case" and "hours of use" will be the same as that used by the Michigan Department of Community Health (MDCH). Per the MDCH, a "surgical case" is a single visit to an operating room during which one or more surgical procedures are performed. Per the MDCH, "hours of use" means the actual time in hours, and parts thereof, an operating room is used to provide surgical services. It is the time from when a patient enters an operating room until that same patient leaves that same operating room. It excludes any pre-operative or post-operative room set-up or clean-up preparations, or any time a patient spends in pre-operative or post-operative areas including a recovery room.

   All ASFs, including ASFs that have more than the minimum number of required operating rooms (as stated in item #10 of this Addendum), must meet the applicable volume minimums. Facility's volumes will be determined by BCBSM via volume attestation reports submitted to BCBSM by Facility. Volume reports must be signed by Facility's owners or officers and clearly identify the type of room in which cases were performed. Procedures performed in a room that is not designated as an operating room on the MDCH's *Annual Hospital Statistical Survey* will not be counted as part of Facility's overall volume. Such submitted volume reports may be audited by BCBSM, at BCBSM's

option. If it is determined by BCBSM that Facility knowingly submitted false information in its attestation volume report, Facility's Agreement will be terminated immediately in accordance with Article V. Section 5.2.e. of this Agreement.

A. Participating ASFs - Recertification Process

ASFs that have been participating with BCBSM for more than 12 months are required to be recertified biannually. Beginning in the year 2003 and every other year thereafter, Facility must submit to BCBSM, by January 31st, its volume attestation reflecting that Facility meets the volume requirement in at least one of the two calendar years between recertification periods. If the Facility meets the volume requirements and all other Qualification Standards, it maintains its participation status until the next recertification period.

If, during such recertification process, Facility meets all Qualification Standards *except* the volume requirement, the following will occur:

1. If Facility meets 90% of the minimum volume requirement (i.e., has a minimum of 1080 surgical cases, or 1440 hours, per operating room for at least one of the two calendar years between recertification periods), Facility will be granted a conditional participation extension. If Facility fails to meet the full volume requirement in at least one of the two calendar years before the next recertification period, Facility will be notified by March 1st of the recertification year that its Agreement will be terminated on May 1st of that same year.

2. If Facility does not meet at least 90% of the volume requirement (i.e., has less than 1080 surgical cases or 1440 hours, per operating room) for at least one of the two calendar years between recertification periods, Facility will be notified by March 1st of the recertification year that its Agreement will be terminated on May 1st of that same year.

3. If Facility does not submit the necessary volume attestation to BCBSM by January 31st of the applicable recertification year, Facility will be notified by March 1st of the recertification year that its Agreement will be terminated on May 1st of that same year in accordance with Article V. Section 5.2.a. of this Agreement.

B. Delicensure of Operating Rooms

If Facility notifies BCBSM of its intention to delicense one or more operating rooms at the time of initial application, or by January 31st of the applicable recertification year, and such delicensing will result in Facility meeting the minimum volume requirement, BCBSM will grant conditional EON approval for 60 days. For the conditional status to be removed and participation continued, Facility must; (i) submit appropriate documentation to BCBSM that the operating room or rooms have been delicensed within 60 days of BCBSM's conditional approval, (ii) meet the volume requirement based on the remaining number of actively licensed operating rooms, and (iii) continue to meet all other Qualification Standards (including the applicable operating room minimum). If all of these requirements are not met, Facility's Agreement will be terminated at the end of the 60 day conditional approval period.

C. Six Month Transition Period

For participating facilities that meet all Qualification Standards *except* the EON requirement, there will be a six month period of transition to the EON volume requirement beginning _____. From this date, participating ASFs will have up to six months to submit to BCBSM their surgical case or hours of use volume attestations for the most recent six month period. The data will then be "annualized" to determine whether it meets the required volume minimums for participating facilities.

Within 30 days of receiving Facility's volume attestation, BCBSM will notify Facility of its eligibility for continued participation status as indicated below:

1. If Facility meets the minimum volume requirement (i.e., has at least 1200 surgical cases or 1600 hours) as well as all other Qualification Standards, Facility will maintain its participation status.

2. If Facility does not meet the minimum volume requirement (i.e., has at least 1200 surgical cases or 1600 hours), its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2.d. of this Agreement.

3. If Facility does not submit the necessary volume attestation by the due date specified by BCBSM, its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2.a. of this Agreement.

6. Patient Care. Facility's patients must be under the care of a licensed Physician. A Physician should be available on-site at all times when a patient is on Facility's premises. Facility should make provisions for patient care services that are appropriate to the needs of the patients and the community it serves.

7. Medical Staff. Facility must have an organized medical staff, established in accordance with policies and procedures developed by Facility, which shall be responsible for maintaining proper standards of medical care.

Membership on the medical staff shall be available to qualified Physicians in the community. Criteria for membership on the medical staff will be established and enforced by a credentials evaluation program established by Facility.

8. Relationship with Hospitals. Facility must have a written agreement with at least one acute care general hospital within reasonable travel time, as determined by BCBSM, to facilitate prompt transfer of patients requiring hospital care. The written agreements with hospitals shall provide that copies of Facility's medical records shall be transmitted to the hospital to which the patient is transferred.

9. Utilization Management and Peer Review. Facility must demonstrate that it conducts program evaluation, utilization review and peer review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components applicable to all patient services in accordance with the requirements of BCBSM and the appropriate accrediting and regulatory agencies.

The utilization management and peer review program will:

- Assess the quality of care rendered to patients to assure that proper services are provided at the proper time by qualified individuals
- Identify, refer, report and follow up on quality of care issues and problems, and

- Monitor all aspects of patient care delivery.

The utilization management and peer review plan must be written and must identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan, including:

- Quality, content and completeness of medical records
- Clinical performance
- Quality and appropriateness of diagnostic and treatment procedures
- Evaluation of tissue specimens
- Medication utilization
- Patient satisfaction
- Quality and appropriateness of anesthesia, and
- Arrangements for patients requiring hospitalization following ambulatory surgery.

10. Operating Rooms. Facility must have a minimum number of operating rooms as specified below. To qualify as an "operating room", the room must be designated as such by the MDCH in its *Annual Hospital Statistical Survey*. Rooms not designated by MDCH as an operating room (e.g., treatment rooms) will not be included in the minimum. A facility that has more than the minimum number of operating rooms must still meet all Qualification Standards and all EON volume requirements described in Item #5 of this Addendum.

A. Multi-Specialty Facilities – Multi-specialty facilities located in non-rural counties (per the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available) must have a minimum of three (3) operating rooms. Multi-Specialty Facilities in rural counties must have a minimum of two (2) operating rooms. For the purposes of this Agreement "multi-specialty" means any facility that performs surgery within two or more different body systems. Examples of "body systems" are; integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/occular adnexa, auditory, etc..

B. Single-Specialty Facilities – Single-specialty facilities located in non-rural counties (per the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available) must have a minimum of two (2) operating rooms. Single-specialty facilities located in rural counties must have a minimum of one (1) operating room. For the purposes of this Agreement "single-specialty" means any facility that performs surgery within only one body system. Examples of "body systems" are; integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/occular adnexa, auditory, etc.

An ASF that wishes to qualify as a single-specialty ASF must attest on its attestation volume report that its services are limited to a specific specialty. If a single-specialty ASF submits claims to BCSM for Covered Services outside of its designated specialty, Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2.a. of this Agreement.

11. Sponsorship, Ownership and Control. Facility must have a governing board that is legally responsible for the total operation of Facility, and for ensuring that quality medical care is provided in a safe environment.

12. Financial Affairs. Facility must conduct its financial affairs in a manner consistent with prudent fiscal management. Records of its transactions shall be maintained in

conformity with generally accepted accounting principles, and with BCBSM billing, reporting and reimbursement policies and procedures.

ADDENDUM B

REIMBURSEMENT METHODOLOGY

For Covered Services provided under this Agreement, BCBSM will pay Facility the lesser of Facility's charge or the ASF fee that is in effect on the date of service, less any applicable Member copayments or deductibles. ASF fees will be established using the following methodologies:

1. Outpatient Surgical Procedures:

   a. "Nominal Priced-Based Payment" for procedures commonly performed in physicians' offices, as determined by BCBSM. The payment will be based on 50% of the physician practice expense of the BCBSM physician fee for each procedure.

   b. "Statewide Percentage of Charges Payment" for procedures that are *not* commonly performed in physicians' offices, as determined by BCBSM, and for which BCBSM has insufficient utilization data to establish a reasonable price. Payment will be the approved charge multiplied by the statewide percentage of charges as determined by BCBSM.

   c. "Price Based Payment" for procedures that are not commonly performed in physicians' offices, as determined by BCBSM. The Price Based Payment is based on a conversion of billed charges to costs, and a BCBSM determined surgical pricing formula.

2. Laboratory and Radiology Procedures:

   a. Payments will be price-based using the technical component of the BCBSM physician fee for each procedure.

3. Other Procedures:

   a. EKGs are reimbursed a "Statewide Percentage of Charge Payment".

BCBSM will review Ambulatory Surgery Facility reimbursement periodically to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Notice of revisions to the ASF fees will be provided by BCBSM in advance of the effective date of the revisions. BCBSM will give Facility not less than 60 days prior notice of any material change to the Reimbursement Methodology used for establishing ASF fees.

Any required notice of reimbursement changes may, at BCBSM's option, be published in the appropriate BCBSM publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility.

ADDENDUM C

APPEALS PROCESS
FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Facility must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW

Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, Facility shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For individual claims disputes:

Provider Appeals Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For disputes regarding utilization review audit results:

Manager, Facility Utilization Review
Mail Code J 105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of Facility's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If Facility is dissatisfied with the determination of the Written Complaint/ Reconsideration Review, Facility may submit a written request for a Managerial-Level Review Conference (Conference). The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. Facility or Facility's representative will normally be in attendance to present its case. The Conference can be held by telephone if Facility prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

For Conferences regarding utilization review audit results disputes:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

A request for a Managerial-Level Review Conference must include the following:

--- Area of dispute;
--- Reason for disagreement;
--- Any additional supportive documentation; and
--- Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to Facility in writing within 30 days of the request for the Conference. The determination of a Managerial-Level Review Conference delineates the following, as appropriate:

1) The proposed resolution;

2) The facts, along with supporting documentation, on which the proposed resolution was based.

3) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;

4) A statement describing the status of each claim involved in the dispute; and

5) If the determination is not in concurrence with Facility's appeal, a statement explaining Facility's right to appeal the matter to the Michigan Insurance Bureau within 120 days after receipt of BCBSM's written response to the Conference, as well as Facility's option to request External Peer Review (Medical Necessity issues only), request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving issues of Medical Necessity that are resultant from medical record reviews, Facility may submit a written request for an External Peer Review if Facility is dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, Facility can request a review by an external peer review organization to review the medical record in dispute. Facility will normally be notified of the determinations made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon Facility and BCBSM.

If BCBSM's findings are upheld on appeal, Facility will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of Facility's right to appeal any Medical Necessity issues to the Insurance Bureau or to initiate an action on those issues in a state court.

Facility's request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

INTERNAL REVIEW COMMITTEE

For disputes involving administrative and/or billing and coding issues, Facility may submit a written request for a review by the BCBSM Internal Review Committee which is composed of three members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM's response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. Facility, or Facility's representative upon Facility's written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Director, Utilization Management
Mail Code J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Facility is dissatisfied with the determination of the Internal Review Committee, Facility may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's Board of Directors) or directly to the Michigan Insurance Bureau; or initiate an action in an appropriate state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Facility may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee), a subcommittee of the BCBSM board of directors composed of BCBSM participating professionals, community leaders, and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. Facility must represent himself or herself at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

Director, Utilization Management
Mail Code J 423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Facility is dissatisfied with the determination of the Provider Relations Committee, Facility may appeal the determination to the Michigan Insurance Bureau, or initiate an action in an appropriate state court.

MICHIGAN INSURANCE BUREAU

Informal Review and Determination

If Facility is dissatisfied with BCBSM's response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if Facility believes that BCBSM has violated a provision of either Section 402 or 403 of Public Act 350, Facility shall have the right to submit a request to the Michigan Insurance Bureau for an Informal Review and Determination.

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of Public Act 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Michigan Insurance Bureau
Post Office Box 30220
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Insurance Bureau. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Insurance Bureau shall issue its determination.

Contested Case Hearing

If dissatisfied with the Insurance Bureau's determination, either Facility or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Insurance Bureau's determination is mailed, and shall be mailed to the Insurance Bureau at the same address found in the prior step.

CIVIL COURT REVIEW

Either Facility or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

STATE COURT SYSTEM

Also, as noted above, at any time after the completion of the Written Complaint or Reconsideration Review and Management Review Conference steps, Facility may attempt to resolve the dispute by initiating an action in the appropriate state court.

ADDENDUM D

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of Members and the confidentiality of personal data, personal information, and Provider financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. that requires BCBSM's board of directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of personal data".

In adopting this policy, BCBSM acknowledges the rights of its Members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; and to know it will not be shared with others except for legitimate business purposes or in accordance with a Member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a Member, that is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a Member, including an automated or computer accessible record, containing information such as an address, age/birth date, coordination of benefits data, that is maintained or stored by a health care corporation.

The term "Facility financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain Facility financial data and information as confidential.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to Members will notify Members of these routine uses and contain the Member's consent to release data for these purposes. These forms will also advise the Members of their rights under this policy.

Upon request, a Member will be notified regarding the actual release of personal data.

BCBSM will not release Member specific personal data except on a legitimate need to know basis or where the Member has given specific authorization. Data released with the Member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the Member executes in writing another prior and specific informed

consent authorizing the additional release. Where protected by specific statutory authority, Member specific data will not be released without appropriate authorization.

Experience-rated and self-funded customers may obtain personal data and Facility financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to customers will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

ADDENDUM E

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Facility will furnish a claim or report to BCBSM in the form and manner BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge to BCBSM or Member, with complete and accurate information, including diagnosis with revenue/procedure codes approved by BCBSM, and such other information as may be required by BCBSM to adjudicate claims.

Facility will use a provider identification number/facility code acceptable to BCBSM for the billing of Covered Services. Facility will only bill BCBSM for services provided by the Approved Site.

Facility agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for Covered Services by requesting information from Members, including but not limited to information pertaining to workers' compensation, other group health insurance, third party liability and other coverages. Facility further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Facility is aware the patient has primary coverage with another third party payer or entity, Facility agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Facility shall promptly report to BCBSM any overpayments Facility receives resulting from BCBSM claims payment errors or Facility billing errors, and agrees BCBSM will be permitted to deduct overpayments, whether discovered by Facility or BCBSM, from future BCBSM payments. BCBSM shall provide an explanation of the credit action taken.

SERVICES FOR WHICH FACILITY MAY BILL MEMBER

Facility may bill Member for:

1. Noncovered Services, unless the service has been deemed a Noncovered Service solely as a result of a determination by a Physician acting for BCBSM that the service was not Medically Necessary, in which case, Facility assumes full financial responsibility for the denied claims. Facility may bill the Member for claims denied as Medically Unnecessary only as stated in paragraph 2., below;

2. Services determined by BCBSM to be Medically Unnecessary, where the Member acknowledges that BCBSM will not make payment for such services, and the Member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;

3. Covered Services denied by BCBSM as untimely billed, if all of the following requirements are met:

    a. Facility documents that an acceptable claim was not submitted to BCBSM within 12 months of performance of such services because a Member failed to provide proper identifying information; and

    b. Facility submits a claim to BCBSM for consideration for payment within three months after obtaining the necessary information.

ADDENDUM G

UTILIZATION REVIEW AND CLAIMS PAYMENT AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Members' medical records or other pertinent records of Facility to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Facility for the reasonable copying expense incurred by Facility where Facility copies records requested by BCBSM in connection with BCBSM audit activities.

Facility shall prepare and maintain all appropriate records on all Members receiving services. Facility shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to Facilities by BCBSM, and such requirements subsequently developed that are communicated to Facility prior to their implementation, and as required by state and federal law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verification of services provided, Facility's adherence to BCBSM's published policies, Medical Necessity of services provided, and appropriateness of revenue/procedure codes reported to BCBSM.

III. Time

BCBSM may conduct on-site inspections and audits during Facility's regular business hours. Facility agrees to allow such on-site inspections and audits within 30 days of the request by BCBSM. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery/Payment of Interest

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria, services not verified in Facility's records, services not billed in accordance with BCBSM's published policies, services provided by a site that was not an Approved Site, and services that are not Medically Necessary as determined by BCBSM. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, revenue/procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries. Facility agrees BCBSM will be permitted to deduct such overpayments from future BCBSM payments. BCBSM shall provide an explanation of the credit action taken and may continue deductions until the full amount is recovered. In audit refund recovery situations, where Facility appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, whichever occurs first. If audit refund recoveries and other overpayment obligations are not fully repaid over the course of one month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.

BLUE CROSS BLUE SHIELD OF MICHIGAN
AMBULATORY SURGERY FACILITY
PARTICIPATION AGREEMENT

This Agreement is made by and between Blue Cross Blue Shield of Michigan (BCBSM) and _____, (Facility), an Ambulatory Surgery Facility, whose address is _____.

ARTICLE I
DEFINITIONS

1.1 **"Agreement"** means this Agreement, all exhibits, and addenda attached hereto, or other documents expressly incorporated herein.

1.2 **"Ambulatory Surgery Facility" or "ASF"** means a facility that provides outpatient ambulatory surgery Covered Services and that meets all the Qualifications Standards stated in Addendum A.

1.3 **"Approved Site"** means the Ambulatory Surgery Facility location specifically approved and contracted by BCBSM.

1.4 **"Certificate"** means benefit plan descriptions under the sponsorship of BCBSM or other Blue Cross and Blue Shield (BCBS) Plans, or certificates and riders issued by or under their sponsorship, or arrangements with any employer group, including any self-funded plan, where BCBSM or other BCBS Plans administer benefits; and, unless the subject of a separate agreement with Facility, any Preferred Provider Organizations (PPOs) or other alternative delivery system owned, controlled, administered or operated in whole or part by BCBSM, excluding BCBSM's subsidiaries, or by other BCBS Plans.

1.5 **"Covered Services"** means those ambulatory surgery facility services that are (i) listed or provided for in Certificates, and (ii) provided at an Approved Site.

1.6 **"Medically Necessary"** means a determination by Physicians acting for BCBSM that a Covered Service meets all of the following conditions: (i) it is rendered for the treatment, diagnosis or symptoms of an injury, condition or disease; (ii) the care, treatment or supply is appropriate given the symptoms, and is consistent with the diagnosis, "Appropriate" means that the type, level, and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment; (iii) it is not mainly for the convenience of the Member or of the Member's health care provider; (iv) it is not treatment that is generally regarded as experimental or investigational by BCBSM; and (v) it is not determined to be medically inappropriate.

1.7 **"Member"** means a person entitled to receive Covered Services pursuant to Certificates.

1.8 **"Noncovered Services"** means those services that are not Covered Services.

1.9 **"Qualification Standards"** means those criteria established by BCBSM that are used to determine Facility's eligibility to become or remain a participating Ambulatory Surgery Facility as set forth Addendum A.

1.10 **"Physician"**, for the limited purposes of this Agreement, means a medical doctor (MD), a doctor of osteopathy (DO), or doctor of podiatry (DPM), licensed in Michigan.

1.11 **"Reimbursement Methodology"** means the methodology by which BCBSM determines the amount of payment due Facility for Covered Services as set forth in Addendum B.

ARTICLE II
FACILITY RESPONSIBILITIES

2.1 **Services to Members.** Facility, within the limitations of its licensed scope of services, will provide Covered Services to Members based on requirements in Members' Certificates and as governed by the terms and conditions of this Agreement and all other BCBSM policies in effect on the date Covered Services are provided.

2.2 **Qualification Standards.** Facility will comply with the Qualification Standards established by BCBSM and further agrees that BCBSM has sole discretion to amend and modify these Qualification Standards from time to time, provided BCBSM will not implement any changes in the Qualification Standards without 60 days prior written notice to Facility. Upon request, Facility will submit to BCBSM evidence of continuing compliance with all Qualification Standards. Notice of changes to Qualification Standards may be given as stated in Section 5.12, or, at BCBSM's option, by publication in the appropriate BCBSM provider publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility. The current Qualification Standards are set forth in Addendum A.

2.3 **Listing of Facilities.** Facility agrees that BCBSM shall have the right to include Facility's name, address and location in listings or other written documents provided for assisting Members to obtain Covered Services from a participating Ambulatory Surgery Facility.

2.4 **Claims Submission.** Facility will submit acceptable claims for Covered Services directly to BCBSM using BCBSM approved claim forms, direct data entry systems, tape-to-tape systems or such other methods as BCBSM may approve from time to time. An "acceptable claim" is one that complies with the requirements as stated in appropriately published BCBSM administrative manuals or additional published guidelines or criteria.

Acceptable claims for Covered Services shall be submitted within 12 months of the date of service. Claims submitted more than 12 months following the date of service, shall not be entitled to reimbursement except as set forth in Addendum F. Facility will endeavor to file complete and accurate claims and report overpayments in accordance with the Service Reporting and Claims Overpayment Policy attached as Addendum E.

2.5 **BCBSM Payment.** Facility will only look to BCBSM for reimbursement for Covered Services and will request reimbursement from Members only for applicable deductibles and copayments for Covered Services, or for services it furnishes that are not Covered Services. Facility agrees not to collect any further payment, except as provided in Addendum F. Facility may not request or require Members to sign an agreement or form to reimburse Facility for any charges in excess of BCBSM's reimbursement for Covered Services, unless otherwise stated in this Agreement. Facility may not collect deposits from Members for Covered Services. Facility may not waive copayments and/or deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member's record or where reasonable efforts to collect have failed.

2.6 **Utilization and Quality Programs.** Facility will adhere to BCBSM's published policies, procedures, and requirements regarding utilization review, quality assessment, quality improvement, patient satisfaction surveys, preauthorization, case management, disease management, or other programs established or modified by BCBSM. BCBSM agrees to furnish Facility with information necessary to adhere to such programs, policies and procedures.

2.7 **BCBSM Access to Records.** BCBSM represents that Members, by contract, as a condition precedent to receiving benefits, agree to the release of information and records to BCBSM from Facility and Physicians, including but not limited to, all medical and other information relating to their care and treatment. Facility shall obtain any further releases or waivers it believes are necessary for the purpose of providing to BCBSM Member medical and billing records related to Covered Services. Facility will release patient information and records within 30 days of BCBSM's request to enable BCBSM to process claims, to verify compliance with BCBSM's Qualification Standards, and for prepayment or postpayment review of medical records that relate to filed claims.

2.8 **Confidentiality.** Facility will maintain the confidentiality of the medical records and related information of Members as required in this Agreement and in accordance with applicable state and federal law.

2.9 **Approved Site.** Facility's Approved Site must be specifically approved by BCBSM. Facility's Approved Site is listed in the Signature Document to this Agreement.

2.10 **Records and Record Retention.** Facility will prepare and maintain all appropriate medical and financial records related to Covered Services provided to Members as required by BCBSM published policies and procedures and as required by law.

2.11 **Audits and Recovery.** Subject to all applicable laws and the confidentiality provisions set forth in this Agreement, Facility agrees that:

a.) Medical Record and Billing Reviews. BCBSM may photocopy, review and audit Facility's records to determine program compliance. Such audits include, but are not limited to, verification of services provided, adherence to BCBSM's published policies, Medical Necessity of services provided, and appropriateness of revenue/procedure codes reported to BCBSM. BCBSM is entitled to obtain recoveries based on such audits as set forth in Addendum G.

b.) Financial Audits. Facility will allow BCBSM to conduct reasonable audits of Facility's financial records. Facility will provide BCBSM with on-site access during Facility's regular business hours to financial records as may be necessary for validating Facility's compliance with Qualification Standards, or for establishing or validating appropriate reimbursement under this Agreement.

2.12 **Facility Changes.** Facility will notify BCBSM, in writing, at least 30 days prior to implementation of major changes, such as, but not limited to, changes in: (i) name; (ii) location; or (iii) ownership. Facility will also notify BCBSM within five business days of Facility's knowledge of any material changes in Facility's professional and administrative staffing; reduction or expansion of surgical services provided if relevant to BCBSM's determination of Facility's categorization as a single-specialty or multi-specialty ASF as described in Addendum A; any reduction or expansion of the number of Facility's operating rooms; licensure; accreditation; or, Medicare certification. Such prior notification of changes is required so that BCBSM may determine Facility's continued compliance with Qualification Standards and contractual obligations. Prior notification of

major program or administrative changes, such as changes in location and ownership, does not ensure continued Facility approval by BCBSM. Ownership and location changes, as well as other major changes, require specific BCBSM approval for continued participation by Facility.

Facility will also notify BCBSM of any actions, policies, determinations, or internal or external developments that may have a direct impact on the provision of Covered Services to Members. Such notification includes, but is not limited to, any legal or government action initiated against the Facility, or any of its owners, officers, directors or employees that affects this Agreement, including but not limited to any action for professional negligence, fraud, violation of any law, or against any health care license.

2.13 **Successor's Obligations.** Facility will require any prospective successor to its interest to assume liability for any amounts for which Facility is indebted to BCBSM, whether evidenced by a promissory note or otherwise. Such assumption of liability shall be one of the conditions for BCBSM approval of any successor in interest as a participating Facility. Such assumption of liability shall not release Facility from the indebtedness unless an agreement to that effect is entered into between BCBSM, the Facility, and any prospective successor, or the successor is a participating Facility and expressly agrees to assume Facility's liabilities to BCBSM.

2.14 **State and Federal Laws.** Facility will provide Covered Services in a manner which conforms to (i) all applicable federal, state and local laws, rules and regulations, and (ii) the standards of professional conduct and practice prevailing in the applicable community during this Agreement.

2.15 **Subcontracting.** Facility must have a written contract with all subcontracted staff. Facility is responsible for ensuring that the subcontracted staff (i) is qualified to perform the service they are subcontracted to perform, (ii) meets and maintains any relevant Qualification Standards, and (iii) adheres to BCBSM's published policies and procedures. Facility remains responsible for the acts or omissions of its subcontracted staff. Facility will furnish a copy of such subcontract to BCBSM upon request.

2.16 **Approved Site.** Facility's Approved Site is listed in the Signature Document.

2.17 **Transfer of Services by BCBSM.** Facility understands that BCBSM administers and underwrites business, parts of which may be conducted through third party administration and managed services, and may conduct business through representatives and agents. Facility agrees to the transfer of the rights, obligations and duties of the parties to this Agreement to those representatives and agents for the limited purpose of performing their respective agreements with BCBSM.

ARTICLE III
BCBSM RESPONSIBILITIES

3.1 **General.** BCBSM's payment obligations pursuant to this Agreement will be limited to Covered Services provided by Facility in accordance with the terms and conditions contained herein.

3.2 **Member Identification.** BCBSM shall provide Members with identification cards and with written information necessary to inform Members of the procedures for obtaining Covered Services from Facility and of their obligations for copayments, deductibles and Noncovered Services.

3.3 **Eligibility and Benefit Verification.** BCBSM will provide Facility with a system and/or method to promptly verify eligibility and benefit coverages of Members; provided that any such verification by BCBSM will be given as a service and not as a guarantee of payment.

3.4 **Claims Processing.** BCBSM will process claims submitted by Facility for Covered Services provided to Members in a timely fashion and in accordance with the terms and conditions contained in this Agreement.

3.5 **BCBSM Reimbursement.** Pursuant to the terms and conditions contained in this Agreement, BCBSM will make direct payment to Facility for Covered Services provided to Members according to the Reimbursement Methodology set forth in Addendum B and as in effect on the dates Covered Services are provided. Reimbursement under this Agreement will not include any amount for professional services but will be limited to facility services, nor will reimbursement include any amounts not properly payable under any coordination of benefits provisions or where another party is liable, in which case BCBSM payment will be the amount BCBSM would have normally paid for such Covered Services less any amount received by Facility from another party.

3.6 **Administrative Manuals and Bulletins.** BCBSM will provide, at no charge to Facility, one copy of administrative manuals, bulletins and such other information and documentation as shall be necessary for Facility to properly provide and be reimbursed for Covered Services provided to Members pursuant to this Agreement.

3.7 **Audits and Recovery.** Audits will be conducted and recoveries obtained in accordance with Section 2.11 and Addendum G of this Agreement.

3.8 **Appeal Processes.** BCBSM will provide an appeal process for Facility in accordance with Addendum C, if Facility disagrees with any claim adjudication or utilization review audit determination.

3.9 **Confidentiality.** BCBSM shall maintain the confidentiality of Members' records and Facility financial information of a confidential or sensitive nature in accordance with BCBSM's Confidentiality Policy in Addendum D. BCBSM will indemnify and hold Facility harmless from any claims or litigation brought by Members asserting any breach of such Confidentiality Policy. This provision will not preclude BCBSM from communicating with its subsidiaries and/or agents regarding Facility information and data, or from communicating with customers regarding aggregate data pertaining to Facility and participating Ambulatory Surgery Facilities.

ARTICLE IV
FACILITY ACKNOWLEDGMENT OF BCBSM SERVICE MARK LICENSEE STATUS

4.1 This contract is between Facility and BCBSM, an independent corporation licensed by the Blue Cross and Blue Shield Association to use the Blue Cross and Blue Shield names and service marks in Michigan. However, BCBSM is not an agent of BCBSA and, by accepting this Agreement, Facility agrees that it made this Agreement based only on what it was told by BCBSM or its agents. Only BCBSM has an obligation to Facility under this Agreement and no other obligations are created or implied by this language.

ARTICLE V
GENERAL PROVISIONS

5.1 **Term.** The term of this Agreement shall begin on the later of February 1, 2002 or the effective date indicated on the Signature Document and shall continue until terminated as provided herein below.

5.2 **Termination.** This Agreement may be terminated as follows:

a. by either party, with or without cause, upon 60 days written notice to the other party;

b. by either party, immediately, where there is a material breach of this Agreement by Facility that is not cured within 30 business days of written notice to the other party;

c. by BCBSM, automatically and without notice, if Facility has its license or accreditation suspended, revoked, or nullified or if Facility or an officer, director, owner or principal of the Facility is convicted of or pleads to a felony or other violation of law;

d. by BCBSM, with 60 days notice, except as otherwise stated in Article V. Section 5.2c, if Facility fails to meet the Qualification Standards set forth in Addendum A.

e. by BCBSM, immediately, if Facility knowingly submits false volume data for the purposes of BCBSM's Evidence of Necessity determination;

f by either party, upon the filing of any involuntary or voluntary proceeding in bankruptcy against either party, insolvency of any party, upon the appointment of a receiver of any party, or any other similar proceeding if such proceedings are not dismissed or withdrawn within 60 days;

g. by either party, immediately, if Facility ceases providing ambulatory surgery services, ceases providing ambulatory surgery services to Members, or ceases doing business;

h. by BCBSM, immediately, at its option, if there is a change in the ownership of Facility; or

i by BCBSM if termination of this Agreement is ordered by the state Insurance Commissioner.

5.3 **Existing Obligations.** Termination of this Agreement shall not in any way affect the obligations of the Parties under this Agreement prior to the date of termination. Such obligations shall include, but are not limited to, completion of all medical records and cooperation with BCBSM with respect to any actions arising out of relationships created by this Agreement filed against BCBSM after the effective date of termination. This Agreement shall remain in effect for the resolution of all matters pending on the date of termination. Upon termination of this Agreement, BCBSM's obligation to reimburse Facility for any Covered Services will be limited to those provided through the date of termination.

5.4 **Right of Recovery.** The expiration or termination of this Agreement or any changes as provided in this Agreement shall not terminate or otherwise limit BCBSM's right of recovery from Facility for overpayments or for recoveries based upon any audit conducted pursuant to the terms of this Agreement. Such rights of BCBSM shall survive the termination of this Agreement.

5.5 **Nondiscrimination.** Facility will not discriminate because of age, sex, race, religion, color, marital status, residence, lawful occupation or national origin, in any area of Facility's operations, including but not limited to employment, patient registration and care, and clinical staff training and selection. Any violation of this provision by Facility shall constitute a material breach and give BCBSM the right to immediately terminate this Agreement as provided in Article V. Section 5.2b. of this Agreement.

5.6 **Relationship of Parties.** BCBSM and Facility are independent entities. Nothing in the Agreement shall be construed or be deemed to create a relationship of employer and employee, or principal and agent, or any relationship other than that of independent parties contracting with each other for the sole purpose of carrying out the provisions of this Agreement.

5.7 **Assignment.** Any assignment of this Agreement by either party without the prior written consent of the other party will be null and void, except as stated in Article II. Section 2.17 of this Agreement.

5.8 **Amendment.** This Agreement may be altered, amended, or modified at any time by the prior written consent of the parties, provided however, that BCBSM shall have the right to unilaterally amend this Agreement upon giving 90 days prior written notice to Facility, or such lesser advance notice as may be otherwise provided in this Agreement. Notice shall be given as provided in Article V. Section 5.12 of this Agreement, or, at BCBSM's option, by publication in the appropriate BCBSM provider publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility.

5.9 **Waiver.** No waiver of any of the provisions of this Agreement shall be valid unless in writing and signed by the appropriate representatives of BCBSM or the Facility, against whom such a waiver is being sought. Any waiver of one or more of the provisions of this Agreement or failure to enforce the Agreement by either of the parties hereto shall not be construed as a waiver of any subsequent breach of the Agreement or any of its provisions.

5.10 **Scope and Effect.** This Agreement along with any attachments shall supersede any and all present or prior agreements and understandings between the parties regarding the subject matter hereof, whether written or oral, shall constitute the entire agreement and understanding between the parties and be binding upon their respective successors and assignees.

5.11 **Severability.** If any provision of this Agreement is deemed or rendered invalid or unenforceable by any state or federal law, rule, regulation or decision of any court of competent jurisdiction, the remaining provisions of this Agreement shall remain in full force and effect; provided, however, should any such invalidity or unenforceability and its removal has the effect of materially changing the obligations of either party, as in the judgment of the party affected, (i) will cause it serious financial hardship, or (ii) cause it to be in violation of its corporate Articles of Incorporation or Bylaws, such party shall have the right to terminate this Agreement upon 30 days prior written notice to the other party.

5.12 **Notices.** Any notice required or permitted under this Agreement shall be given in writing and sent to the other party by hand delivery, or postage prepaid regular mail at the following address or such other address as a party may designate from time to time.

If to BCBSM: If to Facility:

Provider Contracting - B715
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

Address indicated on BCBSM Provider File

5.13 **Third Party Rights.** This Agreement is intended solely for the benefit of the parties and confers no rights of any kind on any third party and may not be enforced except by the parties hereto.

5.14 **Other Agreements.** BCBSM and Facility acknowledge that this Agreement does not limit either party from entering into similar agreements with other parties.

5.15 **Governing Law.** This Agreement will be governed and construed according to the laws of the state of Michigan. Jurisdiction of any dispute will be Michigan.

SIGNATURE DOCUMENT ATTACHED AND MADE A PART HEREOF.

ADDENDA

A. Qualifications Standards

B. Reimbursement Methodology

C. Disputes and Appeals

D Confidentiality Policy

E. Service Reporting and Claims Overpayment Policy

F. Services for Which Facility May Bill Members

G. Audit and Recovery Policy

QUALIFICATION STANDARDS

To qualify as a participating BCBSM Ambulatory Surgery Facility, Facility must meet, and continue to meet the following requirements:

1. Physical Structure and Services. Facility must be a structure, other than the office of a physician, dentist, podiatrist or other private practice office, offering ambulatory surgery and related care that does not require inpatient hospital care.

2. Licensure. Facility must be licensed by the state of Michigan as a Freestanding Surgical Outpatient Facility (FSOF), and meet any requirements of applicable federal law.

3. Accreditation. Facility must be accredited under the appropriate program (i.e., ambulatory health care) by at least one national accreditation organization approved by BCBSM, such as, but not limited to:

   - Joint Commission on Accreditation of Healthcare Organizations (JCAHO),
   - American Osteopathic Association (AOA), or
   - Accreditation Association for Ambulatory Health Care (AAAHC).

4. Medicare Certification. Facility must be certified by Medicare as an Ambulatory Surgery Center, or determined by Medicare to be an extension or part of a Medicare certified hospital.

5. Evidence of Necessity (EON). Facility meets BCBSM's Evidence of Necessity (EON) requirement at the time of initial application, and biennially thereafter through a recertification process. EON requires that Facility operates at a minimum volume of 1200 surgical cases or 1600 hours of use, per operating room per year.

   The term "volume(s)", as used in this Agreement, refers to the number of Facility's surgical cases or hours of use, per operating room per year. For BCBSM's purposes, the definition of a "surgical case" and "hours of use" will be the same as that used by the Michigan Department of Community Health (MDCH). Per the MDCH, a "surgical case" is a single visit to an operating room during which one or more surgical procedures are performed. Per the MDCH, "hours of use" means the actual time in hours, and parts thereof, an operating room is used to provide surgical services. It is the time from when a patient enters an operating room until that same patient leaves that same operating room. It excludes any pre-operative or post-operative room set-up or clean-up preparations, or any time a patient spends in pre-operative or post-operative areas including a recovery room.

   All ASFs, including ASFs that have more than the minimum number of required operating rooms (as stated in item #10 of this Addendum), must meet the applicable volume minimums. Facility's volumes will be determined by BCBSM via volume attestation reports submitted to BCBSM by Facility. Volume reports must be signed by Facility's owners or officers and clearly identify the type of room in which cases were performed. Procedures performed in a room that is not designated as an operating room on the MDCH's *Annual Hospital Statistical Survey* will not be counted as part of Facility's overall volume. Such submitted volume reports may be audited by BCBSM, at BCBSM's option. If it is determined by BCBSM that Facility knowingly submitted false information in its

attestation volume report, Facility's Agreement will be terminated immediately in accordance with Article V. Section 5.2.e. of this Agreement.

A. Participating ASFs - Recertification Process

ASFs that have been participating with BCBSM for more than 12 months are required to be recertified biennially. Beginning in the year 2003 and every other year thereafter, Facility must submit to BCBSM, by January 31st, its volume attestation reflecting that Facility meets the volume requirement in at least one of the two calendar years between recertification periods. If the Facility meets the volume requirements and all other Qualification Standards, it maintains its participation status until the next recertification period.

If, during such recertification process, Facility meets all Qualification Standards *except* the volume requirement, the following will occur:

1. If Facility meets 90% of the minimum volume requirement (i.e., has a minimum of 1080 surgical cases, or 1440 hours, per operating room for at least one of the two calendar years between recertification periods), Facility will be granted a conditional participation extension. If Facility fails to meet the full volume requirement in at least one of the two calendar years before the next recertification period, Facility will be notified by March 1st of the recertification year that its Agreement will be terminated on May 1st of that same year.

2. If Facility does not meet at least 90% of the volume requirement (i.e., has less than 1080 surgical cases or 1440 hours, per operating room) for at least one of the two calendar years between recertification periods, Facility will be notified by March 1st of the recertification year that its Agreement will be terminated on May 1st of that same year.

3. If Facility does not submit the necessary volume attestation to BCBSM by January 31st of the applicable recertification year, Facility will be notified by March 1st of the recertification year that its Agreement will be terminated on May 1st of that same year in accordance with Article V. Section 5.2.a. of this Agreement.

B. Delicensure of Operating Rooms

If Facility notifies BCBSM of its intention to delicense one or more operating rooms at the time of initial application, or by January 31st of the applicable recertification year, and such delicensing will result in Facility meeting the minimum volume requirement, BCBSM will grant conditional EON approval for 60 days. For the conditional status to be removed and participation continued, Facility must; (i) submit appropriate documentation to BCBSM that the operating room or rooms have been delicensed within 60 days of BCBSM's conditional approval, (ii) meet the volume requirement based on the remaining number of actively licensed operating rooms, and (iii) continue to meet all other Qualification Standards (including the applicable operating room minimum). If all of these requirements are not met, Facility's Agreement will be terminated at the end of the 60 day conditional approval period.

C. Six Month Transition Period

For participating facilities that meet all Qualification Standards *except* the EON requirement, there will be a six month period of transition to the EON volume requirement beginning February 1, 2002. From this date, participating ASFs will have

up to six months to submit to BCBSM their surgical case or hours of use volume attestations for the most recent six month period. The data will then be "annualized" to determine whether it meets the required volume minimums for participating facilities.

Within 30 days of receiving Facility's volume attestation, BCBSM will notify Facility of its eligibility for continued participation status as indicated below:

1. If Facility meets the minimum volume requirement (i.e., has at least 1200 surgical cases or 1600 hours) as well as all other Qualification Standards, Facility will maintain its participation status.

2. If Facility does not meet the minimum volume requirement (i.e., has less than 1200 surgical cases or 1600 hours), its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2.d. of this Agreement.

3. If Facility does not submit the necessary volume attestation by the due date specified by BCBSM, its Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2.a. of this Agreement.

6. Patient Care. Facility's patients must be under the care of a licensed Physician. A Physician should be available on-site at all times when a patient is on Facility's premises. Facility should make provisions for patient care services that are appropriate to the needs of the patients and the community it serves.

7. Medical Staff. Facility must have an organized medical staff, established in accordance with policies and procedures developed by Facility, which shall be responsible for maintaining proper standards of medical care.

   Membership on the medical staff shall be available to qualified Physicians in the community. Criteria for membership on the medical staff will be established and enforced by a credentials evaluation program established by Facility.

8. Relationship with Hospitals. Facility must have a written agreement with at least one acute care general hospital within reasonable travel time, as determined by BCBSM, to facilitate prompt transfer of patients requiring hospital care. The written agreements with hospitals shall provide that copies of Facility's medical records shall be transmitted to the hospital to which the patient is transferred.

9. Utilization Management and Peer Review. Facility must demonstrate that it conducts program evaluation, utilization review and peer review to assess the appropriateness, adequacy and effectiveness of the program's administrative and clinical components applicable to all patient services in accordance with the requirements of BCBSM and the appropriate accrediting and regulatory agencies.

   The utilization management and peer review program will:

   - Assess the quality of care rendered to patients to assure that proper services are provided at the proper time by qualified individuals
   - Identify, refer, report and follow up on quality of care issues and problems, and
   - Monitor all aspects of patient care delivery.

The utilization management and peer review plan must be written and must identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan, including:

- Quality, content and completeness of medical records
- Clinical performance
- Quality and appropriateness of diagnostic and treatment procedures
- Evaluation of tissue specimens
- Medication utilization
- Patient satisfaction
- Quality and appropriateness of anesthesia, and
- Arrangements for patients requiring hospitalization following ambulatory surgery.

10. Operating Rooms. Facility must have a minimum number of operating rooms as specified below. To qualify as an "operating room", the room must be designated as such by the MDCH in its *Annual Hospital Statistical Survey*. Rooms not designated by MDCH as an operating room (e.g., treatment rooms) will not be included in the minimum. A facility that has more than the minimum number of operating rooms must still meet all Qualification Standards and all EON volume requirements described in Item #5 of this Addendum.

A. Multi-Specialty Facilities – Multi-specialty facilities located in non-rural counties (per the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available) must have a minimum of three (3) operating rooms. Multi-Specialty Facilities in rural counties must have a minimum of two (2) operating rooms. For the purposes of this Agreement "multi-specialty" means any facility that performs surgery within two or more different body systems. Examples of "body systems" are; integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/occular adnexa, auditory, etc..

B. Single-Specialty Facilities – Single-specialty facilities located in non-rural counties (per the most recent U.S. Department of Agriculture's *Urban-Rural Continuum Code* publication available) must have a minimum of two (2) operating rooms. Single-specialty facilities located in rural counties must have a minimum of one (1) operating room. For the purposes of this Agreement "single-specialty" means any facility that performs surgery within only one body system. Examples of "body systems" are; integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, female genital, nervous, eye/occular adnexa, auditory, etc.

An ASF that wishes to qualify as a single-specialty ASF must attest on its attestation volume report that its services are limited to a specific specialty. If a single-specialty ASF submits claims to BCSM for Covered Services outside of its designated specialty, Facility's Agreement will be terminated with 60 days notice in accordance with Article V. Section 5.2.a. of this Agreement.

11. Sponsorship, Ownership and Control. Facility must have a governing board that is legally responsible for the total operation of Facility, and for ensuring that quality medical care is provided in a safe environment.

12. Financial Affairs. Facility must conduct its financial affairs in a manner consistent with prudent fiscal management. Records of its transactions shall be maintained in conformity with generally accepted accounting principles, and with BCBSM billing, reporting and reimbursement policies and procedures.

REIMBURSEMENT METHODOLOGY

For Covered Services provided under this Agreement, BCBSM will pay Facility the lesser of Facility's charge or the ASF fee that is in effect on the date of service, less any applicable Member copayments or deductibles. ASF fees will be established using the following methodologies:

1. Outpatient Surgical Procedures:

   a. "Nominal Priced-Based Payment" for procedures commonly performed in physicians' offices, as determined by BCBSM. The payment will be based on 50% of the physician practice expense of the BCBSM physician fee for each procedure.

   b. "Statewide Percentage of Charges Payment" for procedures that are *not* commonly performed in physicians' offices, as determined by BCBSM, and for which BCBSM has insufficient utilization data to establish a reasonable price. Payment will be the approved charge multiplied by the statewide percentage of charges as determined by BCBSM.

   c. "Price Based Payment" for procedures that are not commonly performed in physicians' offices, as determined by BCBSM. The Price Based Payment is based on a conversion of billed charges to costs, and a BCBSM determined surgical pricing formula.

2. Laboratory and Radiology Procedures:

   a. Payments will be price-based using the technical component of the BCBSM physician fee for each procedure.

3. Other Procedures:

   a. EKGs are reimbursed a "Statewide Percentage of Charge Payment".

BCBSM will review Ambulatory Surgery Facility reimbursement periodically to determine if modifications are necessary. BCBSM does not warrant or guarantee that the review process will result in increased reimbursement.

Notice of revisions to the ASF fees will be provided by BCBSM in advance of the effective date of the revisions. BCBSM will give Facility not less than 60 days prior notice of any material change to the Reimbursement Methodology used for establishing ASF fees.

Any required notice of reimbursement changes may, at BCBSM's option, be published in the appropriate BCBSM publication(s) (e.g., *The Hospital & Facility News*). Such publication shall constitute notice to Facility.

ADDENDUM C

APPEALS PROCESS
FOR INDIVIDUAL CLAIMS DISPUTES
AND UTILIZATION REVIEW AUDIT DETERMINATIONS

ROUTINE INQUIRY PROCEDURES AND/OR AUDIT DETERMINATION

Facility must complete BCBSM's routine status inquiry, telephone (optional) and written inquiry procedures (for individual claims disputes), or receive an audit determination before beginning the appeals process.

WRITTEN COMPLAINT / RECONSIDERATION REVIEW

Within 30 days of completing BCBSM's routine written inquiry procedures, or within 30 days of receiving BCBSM's written audit determination, Facility shall begin the appeals process by submitting a Written Complaint and/or a request for a Reconsideration of the Audit Determination. The Written Complaint/Reconsideration Review request should be mailed to:

For individual claims disputes:

Provider Appeals Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For disputes regarding utilization review audit results:

Manager, Facility Utilization Review
Mail Code J 105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

A request for a Reconsideration Review must include the following:

- Area of dispute;
- Reason for disagreement;
- Any additional supportive documentation; and
- Copies of medical records (if not previously submitted)

Within 30 days of receipt of the request for Written Complaint/Reconsideration Review, BCBSM shall provide in writing a specific explanation of all of the reasons for its action that form the basis of Facility's complaint and/or the results of the Reconsideration Review.

MANAGERIAL-LEVEL REVIEW CONFERENCE

If Facility is dissatisfied with the determination of the Written Complaint/ Reconsideration Review, Facility may submit a written request for a Managerial-Level Review Conference

(Conference). The purpose of the Conference is to discuss the dispute in an informal setting, and to explore possible resolution of the dispute. The written request for this Conference must be submitted within 60 days after the receipt of the determination letter from the Written Complaint or Reconsideration Review. If the dispute involves issues of a medical nature, a BCBSM medical consultant may participate in the Conference. If the dispute is non-medical in nature, other appropriate BCBSM personnel will attend. Facility or Facility's representative will normally be in attendance to present its case. The Conference can be held by telephone if Facility prefers. The request for a Conference shall be submitted in writing to BCBSM:

For Conferences regarding individual claims disputes:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

For Conferences regarding utilization review audit results disputes:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

A request for a Managerial-Level Review Conference must include the following:

--- Area of dispute;
--- Reason for disagreement;
--- Any additional supportive documentation; and
--- Copies of medical records (if not previously submitted)

BCBSM will both schedule the Conference and communicate the results to Facility in writing within 30 days of the request for the Conference. The determination of a Managerial-Level Review Conference delineates the following, as appropriate:

1) The proposed resolution;

2) The facts, along with supporting documentation, on which the proposed resolution was based.

3) The specific section or sections of the law, certificate, contract or other written policy or document on which the proposed resolution is based;

4) A statement describing the status of each claim involved in the dispute; and

5) If the determination is not in concurrence with Facility's appeal, a statement explaining Facility's right to appeal the matter to the Michigan Insurance Bureau within 120 days after receipt of BCBSM's written response to the Conference, as well as Facility's option to request External Peer Review (Medical Necessity issues only),

request a review by the BCBSM Internal Review Committee/Provider Relations Committee (administrative, billing and coding issues only), or initiate an action in the appropriate state court.

EXTERNAL PEER REVIEW

For disputes involving issues of Medical Necessity that are resultant from medical record reviews, Facility may submit a written request for an External Peer Review if Facility is dissatisfied with the previous level of appeal. Within 30 days of the Managerial-Level Review Conference determination, Facility can request a review by an external peer review organization to review the medical record in dispute. Facility will normally be notified of the determinations made by the review organization within 60 days of submission of the records to the peer review organization. Such determination will be binding upon Facility and BCBSM.

If BCBSM's findings are upheld on appeal, Facility will pay the review costs associated with the appeal. If BCBSM's findings are reversed by the external peer review organization, BCBSM will pay the review costs associated with the appeal. If BCBSM's findings are partially upheld and partially reversed, the parties will share in the review costs associated with the appeal, in proportion to the results as measured in findings upheld or reversed.

This appeal step ends the appeal process for all Medical Necessity issues arising from any medical record review and operates as a waiver of Facility's right to appeal any Medical Necessity issues to the Insurance Bureau or to initiate an action on those issues in a state court.

Facility's request for External Peer Review for a dispute involving medical record audit results shall be mailed to:

Manager, Facility Utilization Review
Mail Code J105
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

For Individual Claims disputes, a request for External Peer Review shall be mailed to:

Conference Coordination Unit
Mail Code 2005
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2459

INTERNAL REVIEW COMMITTEE

For disputes involving administrative and/or billing and coding issues, Facility may submit a written request for a review by the BCBSM Internal Review Committee which is composed of three members of BCBSM senior management. The request for an IRC hearing shall specify the reasons why the BCBSM policy in dispute is inappropriate or has been wrongly applied, and shall be submitted in writing within 30 days of receipt of BCBSM's response to the Managerial-Level Review Conference. Within 60 days of the request, a meeting will be held. Facility, or

Facility's representative upon Facility's written request, may be present at this hearing. BCBSM will communicate the determination of the Committee within 30 days of the meeting date.

The request for an IRC hearing should be mailed to:

Director, Utilization Management
Mail Code J423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Facility is dissatisfied with the determination of the Internal Review Committee, Facility may appeal the determination to either the Provider Relations Committee (a subcommittee of BCBSM's Board of Directors) or directly to the Michigan Insurance Bureau; or initiate an action in an appropriate state court.

PROVIDER RELATIONS COMMITTEE

If dissatisfied with the decision of the IRC, Facility may, within 30 days of receipt of the IRC determination, submit a written request for a review to the Provider Relations Committee), a subcommittee of the BCBSM board of directors composed of BCBSM participating professionals, community leaders, and BCBSM senior management. BCBSM will acknowledge the receipt of the request and will schedule a meeting with the PRC within 90 days. Facility must represent himself or herself at this level of appeal and an advanced position statement is required. The determination of the PRC may or may not be rendered on the day of the hearing. The PRC's mandate is to render a determination within a "reasonable time"; however these decisions will normally be rendered within 30 days of the date of the hearing. As such, BCBSM will communicate in writing the determination of the PRC within 30 days of the PRC's determination.

The request for a PRC hearing should be mailed to:

Director, Utilization Management
Mail Code J 423
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If Facility is dissatisfied with the determination of the Provider Relations Committee, Facility may appeal the determination to the Michigan Insurance Bureau, or initiate an action in an appropriate state court.

MICHIGAN INSURANCE BUREAU

Informal Review and Determination

If Facility is dissatisfied with BCBSM's response to either the Managerial-Level Review Conference, the Internal Review Committee review or the Provider Relations Committee review, and if Facility believes that BCBSM has violated a provision of either Section 402 or 403 of Public

Act 350, Facility shall have the right to submit a request to the Michigan Insurance Bureau for an Informal Review and Determination.

The request shall be submitted within 120 days of receipt of BCBSM's determination and must specify which provisions of Public Act 350 Sections 402(1) and 403 BCBSM has violated. The request shall be mailed to:

Commissioner of Insurance
Michigan Insurance Bureau
Post Office Box 30220
Lansing, Michigan 48909

The Informal Review and Determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of the Insurance Bureau. Within 10 days of the receipt of position papers or the adjournment of the informal meeting, the Insurance Bureau shall issue its determination.

Contested Case Hearing

If dissatisfied with the Insurance Bureau's determination, either Facility or BCBSM may ask the Insurance Commissioner to have the matter heard by an Administrative Law Judge as a Contested Case under the Michigan Administrative Procedures Act. A Contested Case must be requested in writing within 60 days after the Insurance Bureau's determination is mailed, and shall be mailed to the Insurance Bureau at the same address found in the prior step.

CIVIL COURT REVIEW

Either Facility or BCBSM may appeal the Contested Case result to the Ingham County Circuit Court.

STATE COURT SYSTEM

Also, as noted above, at any time after the completion of the Written Complaint or Reconsideration Review and Management Review Conference steps, Facility may attempt to resolve the dispute by initiating an action in the appropriate state court.

CONFIDENTIALITY POLICY

The purpose of BCBSM's Confidentiality Policy is to provide for protection of the privacy of Members and the confidentiality of personal data, personal information, and Provider financial data and information.

BCBSM's Confidentiality Policy sets forth guidelines conforming to MCLA 550.1101 et seq. that requires BCBSM's board of directors to "establish and make public the policy of the Corporation regarding the protection of the privacy of Members and the confidentiality of personal data".

In adopting this policy, BCBSM acknowledges the rights of its Members to know that personal data and personal information acquired by BCBSM will be treated with respect and reasonable care to ensure confidentiality; and to know it will not be shared with others except for legitimate business purposes or in accordance with a Member's specific consent or specific statutory authority.

The term "personal data" refers to a document incorporating medical or surgical history, care, treatment or service; or any similar record, including an automated or computer accessible record relative to a Member, that is maintained or stored by a health care corporation.

The term "personal information" refers to a document or any similar record relative to a Member, including an automated or computer accessible record, containing information such as an address, age/birth date, coordination of benefits data, that is maintained or stored by a health care corporation.

The term "Facility financial data and information" refers to a document or other record, including automated or computer record, containing paid claims data, including utilization and payment information. BCBSM will maintain Facility financial data and information as confidential.

BCBSM will collect and maintain necessary Member personal data and take reasonable care to secure these records from unauthorized access and disclosure.

Records containing personal data will be used to verify eligibility and properly adjudicate claims. For coordinated benefits, BCBSM will release applicable data to other insurance carriers to determine appropriate liability.

Enrollment applications, claim forms and other communications to Members will notify Members of these routine uses and contain the Member's consent to release data for these purposes. These forms will also advise the Members of their rights under this policy.

Upon request, a Member will be notified regarding the actual release of personal data.

BCBSM will not release Member specific personal data except on a legitimate need to know basis or where the Member has given specific authorization. Data released with the Member's specific authorization will be subject to the condition that the person receiving the data will not release it further unless the Member executes in writing another prior and specific informed

consent authorizing the additional release. Where protected by specific statutory authority, Member specific data will not be released without appropriate authorization.

Experience-rated and self-funded customers may obtain personal data and Facility financial data for auditing and other purposes provided that claims of identifiable Members are protected in accordance with any specific statutory authority. For these requests, the recipients of the data will enter into a confidentiality and indemnification agreement with BCBSM to ensure confidentiality and to hold BCBSM harmless from any resultant claims or litigation.

Parties acting as agents to customers will be required to sign third party agreements with BCBSM and the recipient of the data prohibiting the use, retention or release of data for other purposes or to other parties than those stated in the agreement.

Data released under this Policy will be subject to the condition that the person to whom the disclosure is made will protect and use the data only as authorized by this policy.

BCBSM will release required data pursuant to any federal, state or local statute or regulation.

For civil and criminal investigation, prosecution or litigation, BCBSM will release requested data to the appropriate law enforcement authorities or in response to appropriate legal process.

SERVICE REPORTING AND CLAIMS OVERPAYMENTS

I. Service Reporting

Facility will furnish a claim or report to BCBSM in the form and manner BCBSM specifies and furnish any additional information BCBSM may reasonably request to process or review the claim. All services shall be reported without charge to BCBSM or Member, with complete and accurate information, including diagnosis with revenue/procedure codes approved by BCBSM, and such other information as may be required by BCBSM to adjudicate claims.

Facility will use a provider identification number/facility code acceptable to BCBSM for the billing of Covered Services. Facility will only bill BCBSM for services provided by the Approved Site.

Facility agrees to use reasonable efforts to cooperate with and assist BCBSM in coordinating benefits with other sources of coverage for Covered Services by requesting information from Members, including but not limited to information pertaining to workers' compensation, other group health insurance, third party liability and other coverages. Facility further agrees to identify those Members with Medicare coverage and to bill BCBSM or Medicare consistent with applicable federal and state laws and regulations. When Facility is aware the patient has primary coverage with another third party payer or entity, Facility agrees to submit the claim to that party before submitting a claim for the services to BCBSM.

II. Overpayments

Facility shall promptly report to BCBSM any overpayments Facility receives resulting from BCBSM claims payment errors or Facility billing errors, and agrees BCBSM will be permitted to deduct overpayments, whether discovered by Facility or BCBSM, from future BCBSM payments. BCBSM shall provide an explanation of the credit action taken.

SERVICES FOR WHICH FACILITY MAY BILL MEMBER

Facility may bill Member for:

1. Noncovered Services, unless the service has been deemed a Noncovered Service solely as a result of a determination by a Physician acting for BCBSM that the service was not Medically Necessary, in which case, Facility assumes full financial responsibility for the denied claims. Facility may bill the Member for claims denied as Medically Unnecessary only as stated in paragraph 2., below;

2. Services determined by BCBSM to be Medically Unnecessary, where the Member acknowledges that BCBSM will not make payment for such services, and the Member has assumed financial responsibility for such services in writing and in advance of the receipt of such services;

3. Covered Services denied by BCBSM as untimely billed, if all of the following requirements are met:

    a. Facility documents that an acceptable claim was not submitted to BCBSM within 12 months of performance of such services because a Member failed to provide proper identifying information; and

    b. Facility submits a claim to BCBSM for consideration for payment within three months after obtaining the necessary information.

UTILIZATION REVIEW AND CLAIMS PAYMENT AUDIT AND RECOVERY POLICY

I. Records

BCBSM shall have access to Members' medical records or other pertinent records of Facility to verify Medical Necessity and appropriateness of payment and may inspect and photocopy the records. BCBSM will reimburse Facility for the reasonable copying expense incurred by Facility where Facility copies records requested by BCBSM in connection with BCBSM audit activities.

Facility shall prepare and maintain all appropriate records on all Members receiving services. Facility shall prepare, keep and maintain records in accordance with BCBSM's existing record keeping and documentation requirements and standards previously communicated to Facilities by BCBSM, and such requirements subsequently developed that are communicated to Facility prior to their implementation, and as required by state and federal law.

II. Scope of Audits

Audits may consist of, but are not necessarily limited to, verification of services provided, Facility's adherence to BCBSM's published policies, Medical Necessity of services provided, and appropriateness of revenue/procedure codes reported to BCBSM.

III. Time

BCBSM may conduct on-site inspections and audits during Facility's regular business hours. Facility agrees to allow such on-site inspections and audits within 30 days of the request by BCBSM. BCBSM's inspection, audit and photocopying or duplication shall be allowed during regular business hours, upon reasonable notice of dates and times.

IV. Recovery/Payment of Interest

BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria, services not verified in Facility's records, services not billed in accordance with BCBSM's published policies, services provided by a site that was not an Approved Site, and services that are not Medically Necessary as determined by BCBSM. BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on Medical Necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than Medical Necessity, including, but not limited to, revenue/procedure code billing errors.

BCBSM shall have the right to initiate recovery of amounts paid for services up to two years from the date of payment, except in instances of fraud, as to which there will be no time limit on recoveries. Facility agrees BCBSM will be permitted to deduct such overpayments from future BCBSM payments. BCBSM shall provide an explanation of the credit action taken and may continue deductions until the full amount is recovered. In audit refund recovery situations, where Facility appeals the BCBSM determination, BCBSM will defer deduction of overpayments until the determination, or the last unappealed determination, whichever occurs first. If audit refund recoveries and other overpayment obligations are not fully repaid over the course of one month, they will bear interest at the BCBSM prevailing rate, from the date of the refund request, until fully repaid.

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